Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death pindles margaret Physician/ Medical 4b. City, Town, or Location of Death Examiner (0) uma Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Funeral Days Months 1 □ M 2 🗶 F June 18, Director Maryland 1945 permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Howard Glenwood 1 ☐ Yes 2 🎇 No 10e. Street and Number 14557 Mustang Path 10f. Zip Code 10g. Citizen of What Country? 21738 Funeral USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White If Yes Give Specify: 3X☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Powell Magersupp Dorothy Marie Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Spindler, daughter 14557 Mustang Path Glenwood, MD. 21738 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 NBurial 2 Cremation 3 Removal from State Lakeview Memorial Park 08-22-2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home,
1328 Sulphur Spring Rd 21. Signature of Funeral Service Licensee MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No ō Day Pregnant at time of death ed by the at detached for g 🗌 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed is funeral director, page 2 should be de Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) **Division of Vital** 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No death, within 24 hours after death

To the Funeral Director: A

completely filled in by the f ☐ Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) AUG 23 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 27002 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ 2012 Year 7:35 P August 17, Pauline Smith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Months Director 216-74<del>-</del>3585 1 M 2 🕅 F Jan. 7, 1959 Maryland 53 Usual Residence of Dece show 10b. County 10c. City, Town or Location 10a. State at 10d. Inside City Limits Director Examiner must be notified 28a-f 1 🗌 Yes 2 🔀 No Maryland Bel Air Harford 5 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 1612 Ruger Drive 21015 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Force Black, White, etc. þ "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bertha Lillian Smith William (nmn) Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tra 1612 Ruger Drive, Bel Air, MD 21015 Bernadine Smith / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 8-22-2012 | Bel Air, Maryland of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Due to jor as a consequent, of cause. Enter Underlying Cause (Disease or injury that initiated events Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral ( Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🔲 Yes 2 🔲 No Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Compared to the cause of the ca 29a Certifier (Check 29b. Signature and 29d. Date signed (Month, Day, Year) Du057223 upperchesapeake Drive BelAirmp 32. Registrar's Sig

7

State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Ma		Certificate of		_	Reg. No.	112	2700	4	
			1. Decedent's Neme (First, Middle, La	ist)				2. Date of De	ath	Vaar	3. Time of Death	-	
	Physici /Medio		Steven Alec-De	ean Taylo	r			1UGUST	1 <sup>2</sup>	2012	21:15		
	Examir		4e. Fecility Neme (If not institution, give				4b. City, Town, or Lo	ocation of Deat	h 4c. Cour	nty of Death			
				OF BALT	MORE (In yrs. lest birth	ndav) If Under 1 Yea	SACT MORE	8. Date of Bir	th	9 Righ	nlace (State or Fore	ian	
	Funeral Director			1⊠ M 2□ F		rs. Months Dey		(Month, Da 01/04)	iy, Year)	Nort	place <i>(State or Forei</i> ntry) h Carolin	ia.	
	/land		10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limit	its	
	Mary B-f sh	tor	MD Baltin	nore	Owings	s Mills					1 □ Yes 2 🖔 N	Vo	
	or 28	Jirec	10e. Street end Number			10f. Zip Code			10g. Citizen o	f What Cou	ntry?		
	ath w	rail	9315 Pittsfield			2111				S.A.	and the state of		
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deperment of Heath and Mental Hygiene. Deperment of Heath and Mental Hygiene.  Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N	f Hispanic Origin? (Sp uban, Mexican, Puerto o <i>Specify:</i>	echy resorno Rican, etc.)	Spec	lace - Americal lack, White, cify:			
5	72 ho	ted	15. Decadent's Education (Specify only highest gra	ducation	16e. [	Decedent's Usuel Occ	upation	ina	16b. Kind of	Business/Ir	idustry		
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Maryland	d be f antal h sed of	o Be	Roland Tayl				Beatric		Dixon	amoj			
2 3	shoul nd Me mark	To	19a. Informant's Name/Relationship (		19b.	Mailing Address (Stre				vn, State, Zij	p Code)		
	and 2 alth e 27 ie er tra		Steven V. Taylor	/ Son	93	04 Leigh C	hoice Cour	ct, Owin	ngs Mil	ls, M	ID 21117		
_ 2	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Piece of I cemetery	Disposition (Neme of , cremetory or other p	lace)	Date	20c. Locatio	n - City or To	own, Stete		
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Raltimore	permit Depert import any in		21. Signature of Funetal Service Licer	1see			lress of Facility And helley Dr.	*		-	•		
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· _	vificate be executed by physician and as the buriel-trensit	Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events	METASTA	FTIC Dis	6480 OF	UNIK NOWAL	V PRIM	1A727 08	EIGIN	5 DA7S	,	
68760	ate be hysici the bu	lical	thet initiated events resulting in death; Last	c ( )	ue to (or es e co		0.1.0,1007	, , , , , ,		1		1/3	
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5	hysic this o	5	1 ☐ Yes 2 No	Hospital: 1 Inpatient		Datient 3LI DUA	Other: 4 Nursing Ho				<i>fy</i> )		
2	After funer	ion	27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Dey	Year) 28b. Tii Year) Inj	ury W	lonk?  onk?   Yes 2 □ No	28d. Describe	now injury occ	urrea			
ioi	Atten r deat sctor: by the	fica	3 ☐ Suicide 6 ☐ Could not b		ry - At home, farr	m, street, factory, offic				mber or Rur	ral Route Number,		
É	s efte	Certification:	4 ☐ Homicide	building, etc.	(Specify)			City or 10	wn, Stete)				
	To the Hospital or Attending Physician: The lew requires that the death ce within 24 hours after death the certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use	edicai (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of miner: On the basis of e and manner state	examination end/	deeth occurred et the for investigation, in my	time, date end place, opinion, death occur	and due to the red at the time,	cause(s) and date and place	menner as s e, and due i	steted. to the cause(s)		
	To th To th comp	Me	29b. Signature and title of certifier	21-	115		nse number		29d. Date sig				
			I way lu	COPOVIC	MD	KE	5-000	)	HUGUS	7 17	2012		
			30. Name end eddress of person who	completed cause of dea	ath (Item 23a) (T	ype, Print)	Link mis						
1			11. Date filed (Month, Day, Year)	3/2. Registrer		INC OF 15	TUIN ORE						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2012 Physician/ Crystal Tune 18 11:37 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4822 Hamilton Avenue, Apt 3B **Baltimore** 5. Social Security Number If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year, 213-80-4802 **Director** 1 M 2 PF Yrs 52 02/23/1960 MD 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director MD Baltimore Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 Funeral or items 23a 4822 Hamilton Avenue, Apt 3B 21206 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. med Forces? Black, White, etc þ 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: If Yes, Give Year or Dates Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Samuel Tune Annie Lockhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timera Jefferson / Daughter 1026 Woodson Road, Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Cremation Ctr Of MD 1 Burial 2 Cremation 3 Removal from State 8/25/2012 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Yaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phylician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of, the burial-transit To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) signed by the at the detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Z Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) 10

Registrar
DHMH 17 Rev 06-201

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ Month George Eldridge Trail 10:45 PM August 21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year 219-38-7533 Director 1 ☑ M 2 ☐ F July 11, 1940 Maryĺand 72 Usual Residence of Decedent 2 should be filed within 72 hours efter death with the Meryland th and Mertle Hygiene. 27 is marked other then "neturel", or items 23e or 28e-f show treumetic event, the Medical Examiner must be notified as 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Rockville 1 TV Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 20850 512 Crabb Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 🖾 No 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Lawn Care Lawn Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 end 2 should be fl of Health end Mentel item 27 is marked မ Joseph C. Trail Margaret Peed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 512 Crabb Ave., Rockville, Maryland 20850 Carolyn Trail / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pege 1 e
Depertment of I
Importent: If ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State Aug. 25, 2017 4 Donation 5 Other Specify Parklawn Memorial Park Rockville, Maryland 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc.
300 W. Montgomery Ave., Rockville, Maryland 20850 21. Signature of Funeral Serv -M00896 23a. Part 1. Enter the dise shock, or heart failure Immediate Cause (Final ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Pnysician/ Thyroid Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dispass of inhary Due to (or as a consequence of). Examir ettending physicien end for use es the burlel-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physicien: The lew requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 Other (specify) ed by the e 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be de 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No within 24 hours efter deeth.

To the Funerel Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other:  $_{4\ \square\ Nursing\ Home}$  5  $\square$  Residence 6  $\boxtimes$  Other (Specify) Hospice 1 Tyes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitei Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 .22.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V

DHMH 17 Rev 06-2011

State

Registrar

Debrah Miller, CRNP,

AUG 23

31. Date filed (Month, Day, Year)

32. legis

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GWENDOLYN VANS COY Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** b. City, Town, or Location of Death North East Cecil 80 Bayview Blvd. 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 212-78-7799 1 M 2 K F 50 06/18/1962 Delaware th and Mental Hygiene. 27 is marked other then "natural", or items 23e or 28a-1 shor treumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No North East Cecil 10g. Citizen of What Country? Funeral 80 Bayview Blvd 21901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Š 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Personal Banking Officer Finance Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) ည Williamson Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John Linzy /</u> Husband 80 Bayview Blvd., North East, MD 21901 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 108/22/2012 4 Donation 5 Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BREAST Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami signed by the attending physician and d be detached for use as the burlal-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.
To the Funeral Director. After this certificate has been sign completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.0. Records, **Division of Vital** 

DHMH 17 Rev 06-2011

State Registrar Blub Hen Burge 2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #151atePerman land Debah Archi of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 PM Physician/ Medical City, Town, or Location of Death 4c. County of Death acility Name (if not institution, give street and number) Examiner Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign ast birthday **Funeral** Director 029-02-8370 1 🗆 M 2 🗓 F 28 July 9, 2012 Maryland 28a-f show 10d. Inside City Limits 10h. County 10c. City, Town or Location with the Maryland items 23a or 28a-f sho ner must be notified at Director Maryland Columbia Howard 1 🗆 Yes 2 🙀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 USA 4913 Good Hours Place Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?
1 ☐ Yes 2 🛣 No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry during most of working (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Infant Infant Infant of Health and Mental Hygie If item 27 is marked other or other traumatic event, tt Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Joshua M. White Stephanie Vernon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4913 Good Hours Place, Columbia, Maryland 21044 Stephanie V. White Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific Meadowridge Mem. Park 08/10/ 12 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home eral Service Signativ 7250 Washington Bvld., Elkridge, MD 21075 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the disease, or shock, or heart failure. List o Approximate Interval Between Onset and Death one cause on each lir Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam the Hospital or Attending Physician: The law requires that the death certificate be execute burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the ast attending IF FEMALE: use ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? for Month Day Pregnant at time of death signed by the a 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 2 No page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of 2 No this certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 2 No မ 1 Yes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Pipatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Medical Certificate: Natural 5 Pending n 24 hours after death.

Funeral Director: All letely filled in by the fu 1 Yes 2 No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State 3 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of L		ionital in		eg. No. 201	2 2/00						
Physici ledical Exami		1. Decedent's Name (First, Middle,Last) Alejandro S. Wine			2. Date of Deat Month August 22	Day Year	3. Time of Death 0137 hrs						
1		4a. Facility Name (if not institution, give street and number)  4b.	City, Town, or Local	tion of Death	August ZZ	4c. County of Dea							
		,	Middle River		In a contract of	Baltimore Co							
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 174-76-0172 1XM 2F 7. Age (In yrs. last birthday) 177 Yrs.	9. B Fore 30, 1995	gn									
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											
<b>*</b>	<u>_</u>	MD Baltimore Essex											
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212 ould be Menta mark	To Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing A			a Wine	ber, City or Town, Stat	e, Zip Code)						
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Baltimore permit. Pages 1 Department of F Important: If injury or other		4 Donation 5 Other Specify:	ne and Address of Fa										
Depart		Ale E-Tille	Connelly	Fune	ral Ho	Ave. Ba	sex 21221						
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	mode of dying, such	as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and						
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Box 687 e death certific the attending of	Physician/	past 12 months?  4 Pregnant at time of death 5 Other	(Specify)										
ords, P.O. Box 687 w requires that the death certific s been signed by the attending p		Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given i	in Part I.	23e. Did tol	bacco use contribute to	the cause of death?						
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Division of Vital Records, pital of Attending Physician: The law requirest after death.  seral Director. After this certificate has been sifiled in by the funeral director, page 2 should the page 2 should the page 2 should the page 2 should be a page 2 should the page 2 should the page 2 should be a page 2 should the page 3 should the	ñ. 7	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Μρητή, Day, Year)		In		ow injury occurred ixed object collis	ion						
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To the Ho within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.  29b. Signature and title of certifier	29c. License num		the time, date a	29d. Date signed (Mo							
	~	Carol Hallan	O.C.M.E.			August 22, 2012							
n. 1	ŀ	30. Name and address of person who completed cause of death (Item 23a)	1.		10								
ე√		Carol H. Allan, MD Assistant Medical Examiner 900 W. Bal  31. Date filed (Month, Day Year) 32. Registrar's Signature	timore Street, B	Baltimore,	MD 21223								
Regist	_	AUG 23 2012 June B. Jack											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Pate of Death Physician/ reaver Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death Examiner 27 Terrace Road Baltimore Essex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 219-38-7814 Months Days Director 1 XM 2 TF 69 May15,1943 MD an "natural", or items 23a or 28a-f show Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 27 Terrace Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Zurich Ins. Co. Printer 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filer rtment of Health and Mental H rtant: If item 27 is marked of 18. Mother's Name (First, Middle, Maiden Surname) ည Lee A. Weaver Dorothy McCardle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy J. Weaver /wife Terrace Road Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it
any injury or o 1 Burial 2X Cremation 3 Removal from State Bayview Crematory 271 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Survice Licensee 22. Name and Address of Facility Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 2 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ mongons disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed bunial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buna Physician/Medical Box 68760 as the IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day 1 Yes 2 9 Unknown Yes 2 No the detached Division of Vital Records, P.O. ğ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Onknown Completed filled in by the funeral director, page 2 should this certificate has been 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform 1 Yes 2 No 1 🗌 Yes 2 🜽 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manney Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar o completed cause of death (Item 23a) Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dorothy A. Williams <sup>Day</sup>7,20<sup>ear</sup>2 August 7:14pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care /Rossville Rosedale Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, July4 1 M 2 X Months Hours Min. Country) 220-40-8989 69 Director MD Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director MD Baltimore Essex 1 Yes 2 No 10f. Zip Code r items 23a or ner must be n ö 10e. Street and Number 10g. Citizen of What Country? Funeral 1 Pecan Lane 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 White "natural". Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker own home 9th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Jim Allio မ Hazel Hillbinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby E. Williams /husband 1 Pecan Lane Baltimore MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Bayview Crematory 8/21/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signa of Funeral Service Licensee Balto.MD Connelly Funeral Home of Essex 21221 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each it e Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) as a consequence drees Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit Exami and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown detached g Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes director, page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of s after death. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) ٥ VEOE death (Iter (Item 23a) (Type, Print) n who comp lov 31. Date filed (Month, Day, Year) Registrar's Signature State 23 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month John Warren Woolsey, Day 3:06 P M 2012 Medical August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Mt. Airv Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours **Director** 222-32-4485 1 🔀 M 2 🗆 F 66 Sept 2, New York 1945 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. inside City Limits Director MD Frederick Frederick 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2461 Stoney Creek Road 21701 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. ⋧ 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 【XNo If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u> Mortgage Counselor</u> Banking/Financial permit. Page 1 end 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event; Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ John Warren Woolsey, Sr. Mary Jane Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald D. Heater/life Partner 2461 Stoney Creek Road Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crematory 08/23/12 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Going home Cremation Service P.O. Box 784 Beverly L. MO1251 Heckrotte, P.A Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death months Physician Metastatic Eso ha eal Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? 4 Pregnant 9 Unknown 5 Other (specify) 1 Yes 2 No Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certific: filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) hospice မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 X Natural 5 Pending 2 Accident Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical within 24 hou

To the Funer

completely fil certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Externiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying furse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D61961 August 21, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Taimur M.D. 46-B Thomas Johnson Dr. Frederick, MD 21704 State 32. Registrar's Si Registrar

DHMH 17 Rev 06-2011

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 13, 2012 4:44 P M Lucille Catherine Walsh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St Elizabeth's Nursing & Baltimore City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 🗓 Days Months Hours July 1923 Maryland 215-18-7557 89 Yrs. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No Maryland Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ir than "natural", or items 23a or the Medical Examiner must be Funeral United States 21227 1228 Stevens Ave. death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. ρ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: Specify: White 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) N/A al Hygiene. Elementary/Seconday (0-12) 12th Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important. If item 27 is marked o any injury or other traumatic even n and Mental I ၉ Marie Catherine Bonhoff John Paul Dwayer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Harford Dr., Harmans, Maryland 21077 Edward T. Walsh, Jr. /Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery Aug. 18, 2012 Baltimore, Maryland 20a. Method of Disposition 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Other (Specify) 4 Dopation 22. Name and Address of FaringBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ (arunora disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Hospital or Attending Physician; The law requires that the death Month 5 Other (specify) Pregnant at time of death been signed by the a should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate has page 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Marlos R D240781 20:2

DHMH 17 Rev 7/2009

State

Registrar

1001 PINE HELCOTS AME, 5300

BALTIMORE.

MIP

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRASHAM OR M. O

31. Date filed (Month, Day, Year,

AUG 23 2012

		A	MEND #25, PER MD (	Type or Print in E 930 8/24/12 TR State of Maryland	<b>Jack Indeli</b> 7 Departme	ble Ink. Ensure ent of Health and	All Copies	s <mark>Are Legible</mark> giene	).
		-	For State Registrar			ite of Death		Reg. No. 201	2 27015
	Physicia Medic		1. Decedent's Name (First, Middle, Las	AMES B	ELLA	$m \times$	2. Date of Dea	Day Year	3. Time of Death
	Examir		4a. Facility Name (if not institution, give 5317 Midwox	street and number)  Avenue	4b. Ci	ty, Town, or Location of Deat A HI MORE	th	4c, County of Dea	ath
	Funeral Director		5. Social Security Number 6. St. 251-62-21dde	7. Age (In yrs. las	3 Yrs. If Und	der 1 Year   If Under 24 Hrs		19386	irthplace (State or Foreign ountry)
	land show dat	'n	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	Maryla 28a-f s otified	irect	MD	BA	HIMOR	٠,			1 Ses 2 □ No
	vith the 23a or st be n	Funeral Director	10e. Street and Number 5317 Midwood	A 1. 2	10f. I	Zip Code ZIZIZ		10g. Citizen of What C	Country?
920	death v r items ner mu	þ	11. Marital Status  12 Never Married 2  Married  3  Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes No If Yes, Give Year or Dates.	If Yes, sp	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puer 2 No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	
21215-0036	thin 72 hour sne. than "natu ne Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Seconday (0-12)		life. DO NOT	vork done during most of wo	rking	16b. Kind of Business	_
	ould be filed wird Mental Hygie marked other matic event, tl	To Be	17. Father's Name (First, Middle, Last)	1241	1 1171111	18. Mother's Na	me (First, Middle,	Maiden Surname)	2
Maryland	should the and Me is mark		19a, Informant's Name/Relationship (T)	pe, Print)		ess (Street and Number or Ri	ural Route Numbe	r, City or Town, State, 2	
	1 and 2 should be of Health and Men item 27 is marke other traumatic		Yvonne M. Ard 20a, Method of Disposition	is (SISER)	537 M	idwood Aver	we BAL		
Baltimore,	e = = =		Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	metery, crematory of	r other place)	ulzorz	Horry C	
3alti	permit. Pag Department Important: any injury o		21. Signatule of Funeral Service Licens			and Address of Facility	luchn C.	Greene Fil	neval SCVS
	2020	Н	23a. Part 1. Enter the disease, or comp		Do not enter the m	ode of dying, such as cardia		timore M	Approximate
all the said	Physician/		shock, or heart failure. List only o Immediate Cause (Final disease or condition	a. Acute  Due to (or as a conseque	myo ca	volial in	Lev Ct	704	Interval Between Onset and Death
-	Medical Examiner		resulting in death)	Due to (or as a conseque		WY Luca	10		
	7 #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	ence of):	v p wiser			
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90		dical		d				_	
Box 68760	ires that the death certificate be signed by the attending physici d be detached for use as the bu	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 D Ectop			23d. Date of d Month	elivery Day Year
P.O.	that the led by t detach	y Ph	Part II. Other significant conditions of	ontributing to death but not resul	Iting in the underlyin	g cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
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al Re	sician: The law certificate has rector, page 2.	Be Co	25. Was case referred to medical	ncreatit	2 >	26. Place of Death (Che	1 🗆 Yes		es 2 No
of Vital	hysicia this cer al direct	은	I LI Yes 2 KM NO	Hospital:			T	dence 6 Other (Spe	ecify)
n of	Attending Physician: sr death. ector: After this certific by the funeral director,	cate	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury M	28c. Injury at work? 1  Yes 2 No	28d. Describe h	now injury occurred	
Division		al Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)			City or Tow		
	To the Hospital or within 24 hours after To the Funeral Dir completed filled in	Medical	(Check 2 \( \sum \) Medical Exami	sician: To the best of my knowle ner: On the basis of examination the Practioner: To the best of my	and/or investigation,	in my opinion, death occurred	I at the time, date a	ind place, and due to the	e cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier		2	9c. License number		29d. Date signed (Mor	th, Day, Year)
	(A)		30. Name and address of person who c	ompleted cause of death (Item 2		019589			0-2012
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re / 001 8	orn pa	100050	1111	1 7
	Registr		AUG 24	32. Registrar's Signatu	A bear	as I			

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25 per me, 2930 8-29-12 sm. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Brown 37 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore HOSPITA Johns Hopkins 1+ Y 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours 218-28-3592 Country) Director 1 M 2 X F 27 30 81 12 MD Usual Residence of Decedent or 28e-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28e-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NΑ Baltimore 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 North Central Ave Apt 322 21202 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Public School 12th grade College (1-4 or 5+) 2yrs Substitute Teacher System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Bristol Elizabeth Virginia Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236Cynthia Edell Frazier Greehe 7912 Marfield Place Apt C, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
eny injury or ot Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 8/29/2012 Owings Mills, Md Garrison Forest Vet. 21. Si atlyre of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Pair 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician/ Subarachnoid Hemory have Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): EXAMINER Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran CERTIFICATION APPROVED Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day signed by the af id be detached for 9 Unknown 9 🔲 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No After this certificate 2 🗌 No 1 Tes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 KG Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place only one) and due to the sause(s) and manner as state 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mulder, MD. Maximilian 1800 Orleans Street Baltimore, mD 2128 31. Date filed (Month, Pay, Year) AUG 2 4 2012 32 Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OLLIE, M. BLACK 23:00 Medical AUGUST 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE N/A UNIVERSITY OF MARKLAND 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 215-52-1860 Birthplace (State or Foreign Country) Days Hours Director 1 □ M 2**X** F Yrs 64 04/08/1948 Virginia 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits notified MD N/A 28a-f Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code must be r 10g. Citizen of What Country? Funeral 1315 W. Pratt St. 21223 U.S.A. items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Force Black, White, etc. ō ğ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 'natural" Completed 3 Widowed 4 Divorced Specify: Year or Dates Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. 1 Ith Grade College (1-4 or 5+) the Seamstress Uniflair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Otis Eldridge Sr. other traumatic Rebecca Womack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Ticole Black(daughter) 2023 McHenry St., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory Baltimore, MD Sonature of Funeral Service Lic ਰੇਨਾਵਾਸੀ ਸਿੰਨਿਆ Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between mediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) IDIOPATHIC PULMENARY FIBROSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to influediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical 7 Division of Vital Records, P.O. Box 68760 the as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Pregnant at time of death Day Year the 9 Unknown g 🔀 Unknown signed by hid be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed page certificate 2 X No 2 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Other: ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred X Natural 5 Pending iniury s after death. the Accident Investigation 1 Yes 2 No Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29c. License number 29d. Date signed (Month, Day, Year) Dente le 25582 AUGUST 20 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANTE SUFFREDING UNIVERSITY OF MARYLAND MEDICAL CTR. 22 SOUTH GREENE ST, BALTIMORE, MD 21201

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

32. F

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kodne Bardste August 1:41 Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brightview TOWSON Baltmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Numbe 036-12-2309 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. 90 Country) Director 1 🗗 M 2 🗆 F Jan 7 1922 Rhode Island 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 E. Burke Avenue 21286 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Naval Officer Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Bardslev Viola Buxton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Bardslev / Son 4907 Friendsville Rd. Friendsville, Md. 21531 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State HilltopServiceCorp. 8/23/2012 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fun September 1 Ce 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician Aspiration disease or condition Medical resulting in death) as a consequence of): Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 6 months Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L Be Completed by 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other (Specify) ၉ 1 Tes Other: Facili 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Dun Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 4 ☐ Homícide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D71079 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Cherles Ashleigh M 21204 32. Registrar State Registrar DHMH 17 Rev 06-2011

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #29d Per PHY G930 8/30/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 20<sup>ay</sup> Palmina Joanna Butler 2012 9:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore 917 Beaver Bank Circle 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 214-16-9805 92 1 M 2 X F March 28 1920 Maryland 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Towson 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 917 Beaver Bank Circle 21286 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Midowed 4 Divorced If Yes, Give Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Frank Pecora Agatina Reina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health a tant: If item 27 is 12707 Pond Crest Lane Oak Hill, Virginia 20171 Robert Butler / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1:
Department of I
Important: If it
any injury or of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Redeemer Cemetery 8/24/2012 | Baltimore, Maryland 21. Signature of Funda Comice Lives 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physic any Onset and Death Metastatic Carcinoma mouth Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 4 Pregnant at time of death 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? eral Director: After this certificate has been sir filled in by the funeral director, page 2 should 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 27. Manner of Death Certificate: 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examinating and/or investigating in manifering the state of the cause of the 29a. Certifier within 24 hor

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completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lang August21,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 2 Patrick August 22 11:02A M Berry Sr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1006 Seacrest Ct. Glen Burnie Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) Director 213-80-4620 1 12 M 2 | F 51 Yrs. 6/30/61 Balt. Maryland Usual Residence of Decedent 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 23a or 28a-f sho important: If item 27 is marked outher than "natural", or item 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes ŽXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1006 Seacrest Ct. 21060 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 ANO
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 XNo Specify: white Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck driver Dump trucks Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles F Berry Jr Margaret Cosgrove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Berry spouse 1006 Seacrest Ct. Glen Burnie MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Removal from State Meadowridge Cem August 27,12 Ellicot City MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only ne cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day signed by the at d be detached fo g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 0 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify) After this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No death. the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUTH L. BURGAN AUGUST 22,2012 6:12P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTO. TOWSON GILCHRIST Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Min Hours 219-16-9633 Director 1 M 2 XF 88 8-11-1924 MARYLAND Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits BALTO. BALTO. MD. 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code ms 23a or 10g. Citizen of What Country? Funeral APT. 211 4102 TAYLOR AVENUE USA 21236 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner Armed Force or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE ian "natural", Medical Exar 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) the SUPERVISOR STATE GOVERNMENT ige 1 and 2 should be filed wit nt of Health and Mental Hygie t: If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ANNA C. DIEGERT UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 TREHERNE ROAD TIMONIUM, MD. 21093 SON GARY P. BURGAN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ò cemetery, crematory or other place permit. Page Department ( Important: If any injury or once. 4 Donation 5 Other (Specify) 8-27-2012 TIMONIUM, MD. 21093 DULANEY VALLEY 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 6415 BELAIR ROAD BALTIMORE, MD. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death gertensive Physician) disease or condition resulting in death) -cas Medical (or as a consequence of Examiner myforensin Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to for as a consequency of Examin that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHF, COPD, Coronery an very describe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5  $\square$  Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 1

Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated at Medical Examiner: On the basis of examination and/or investigation in my policies, death occurred at the time, date and place, and due to the cause(s) and manner as stated at Medical Examiner: On the basis of examination and/or investigation in my policies, death occurred at the time, date and place, and due to the cause(s) and manner as stated at the time. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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only one) 29b. Signature and title of certifier

AARON.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Registrar DHMH 17 Rev 06-2011

State

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

6701 N. Charles

AUGUST 23

TONJON MUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Montr 08 15<sup>Day</sup>  $20^{19}$ Willard Robert Blades, Jr. 11:32 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours 219-32-8141 **Director** 1 ☒ M 2 ☐ F 76 05/11/1936 Usual Residence of Decedent 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD 28a-f Harford Conowingo 1 Yes 2 X No 10e. Street and Numbe ms 23a or must be n 10f. Zip Code 10g. Citizen of What Country? 120 Curry Ave. 21918 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ural", or iter Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No If Yes, Give altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify 27 is marked other than "natural", traumatic event, the Medical Exa Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) NSA Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I is marked o Willard R. Blades, Sr. Margaret Shores 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Carole Blades - Spouse 120 Curry Ave., Conowingo, MD 21918 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Doyalion 5 Other (Specify) Atlantic Crematory 08/20/2012 Glen Burnie, MD 21. Signature of Funer of rvise Licens 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd., Bel Air, MD 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ probable Medical resulting in death) Examiner Sequentially list conditions, if any leading to him cloth cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use Live Birth 2 Fetal death
Pregnant at time of all 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 Yes Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No 1 Inpatient 2 R/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Certifical work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) DO057223 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chesapeake Drive BelAir MD 21014-Fermin Upper

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 2012 Physician/ Mary Deloves 21 9:30 P M August Carre Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-42-8375 Director 1 □ M 2 🔀 F 360 Maryland 160 05 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Harford Joppa MD. 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral United States 21085 502 Foster Branch Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Completed by 1X Never Married 2 Married 1 Yes 2 No Specify. White If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည should be Mary E. Miller William C. Cavev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and is m 502 Foster Branch Road, Joppa, Maryland 21085 Charlotte A. Krueger (Niece) Page 1 and 2 27 Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/24/2012 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Annineral Service Licensee Alvson Taylor 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road, Catonsville, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Phairin/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, legacing to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events ny Bar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Box in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 or Attending Physician; The 25. Was case referred to medica 26. Place of Death (Check only one) Be Division of Vital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 🗆 Yes Certificate: To Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 29d. Date signed (Month, Day, Year) nd address of person who completed cause of death, (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) AUG 2 4 2012

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ONES

Cavey

500 upperchesapeake Drive Bel Air MD 2/0/4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#26perDVR, G930, 8/24/2012, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 20 ay 201 Zear Neal James Crowder 12:02 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cecil Caraway Manor E1kton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Pennsylvania Month, Day, Year, 5/7/1919 213-09-4200 **Director** 1 ★ M 2 □ F 93 Usual Residence of Decedent show 10b County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Cecil 1 Yes 2 X No E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 19 Maple Lane United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1X Yes 2 ☐ No If Yes, Give LTU Black, White, etc Completed by 1 Never Married 2 Married 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene.
item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 Year or Dates. WW II 1 ☐ Yes 2X No Specify: White Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) llth N/A Steelworker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sarah J. Dunlevy Charles Thomas Crowder, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. 19 Maple Lane Elkton, Maryland 21921 Matthew S. Crowder Son or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State Sacred Ht of Jesus Cem 8/24/2012 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Scott P Gardner Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset Ind Death Immediate Cause (Final disease or condition Sclentic Physician/ Medical resulting in death) Tenknown Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 Li retail 4 Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) signed by the a d be detached f 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Living within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tippof certifier Suchder-S. MD 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S.S Sachdev MD, 1861, E High SI, Elkum MD 21921.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

### State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9 2012 Linda D. Cottingham Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Square Se Ro a 5 Social Security Number 228-94-2754 (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Months Director 1 □ M 2 🔀 F 50 Yrs 09/22/1961 10b. County 10a. State 10c. City, Town or Location Director notified N/A 28a-f MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö pe ms 23a must be Funeral 1209 N. Potomac St. 21213 U.S.A. office har, Lindo 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes : 1 Yes 2 No Specify: "natural", Specify: Black 3 Divorced 4 Divorced Year or Dates marked other than "nature matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) tary/Secondary (0-12) College (1-4 or 5+) 12th Grade Housewife N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Butch Oglesby Eleanor Smith Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Thomas Williams (Father) 1209 N. Potomac St., Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ō ☐ Burial 2 Cremation 3 ☐ Removal 1 8-22-12 on-site Crematory Baltimore, MD Donation 5 Other (Specify) Signature of Funeral Service Liver プログログログ Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, ea. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ntravascular Coagulopath Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the burial-tran that initiated events resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Completed by Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be-24 hours after death. • Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Pregnant at time of death Other (specify) 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director, After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred injury Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier (Check only one 29b. Signatu

1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. es s of person who completed cause of death (Item 23a) (Type, Print) 4 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Maryland

MD

Day

1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

21217

10d. Inside City Limits

Yes 2 No

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 27027 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 7:15 a<sup>M</sup> CARROLL MARGUERITE August Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE CO. CATONSVILLE MANOR CARE-ROLLING ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 ☐ M 2XXF Months Hours 78 Yrs 1934 MARYLAND Director 220-30-4116 Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City. Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland **Funeral Director** notified 1 X Yes 2 No BALTIMORE MARYLAND N/A 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? must be 23a U.S.A. 21206 5620 WHITBY RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Black White etc 20 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK 3XXWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE CASHIER 10th grade f Health and Mental Hygier item 27 is marked other to other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ RUBY PENIX ULYSSES BELLAMY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 Whitby Rd., Baltimore, Maryland 21206 David M. Johnson/Grandson other 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date of 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once. BALTIMORE, MARYLAND METRO CREMATORY 08 - 24 - 124 ☐ Donation 5 ☐ Other (Specify) 21. Signal e of Funeral Service Lisens 22. Name and Address of Facility WILLIAM C BROWN COM 1206 W NORTH AVENUE COMMUNITY FUNERAL HOME P.A. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Anset and Death NEUMONIA Physician/ INO WOOKS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 menths?

1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Yes 2 No Natural 5 Pending injury Accident
Sulcide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: No the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and tit

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UAINDO

BENEZEN

Date filed (Month, Day, Year)

00061765

350 WILKERS AUG #307 BAC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06134 State of Maryland / Department of Health and Mental Hygiene Brenda Cammon 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 15, 2012 1412 hrs **Medical Examiner** Cammon Brenda 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Saint Agnes Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreian Months Davs Hours 04-03-50 Director Country) NC 1 M 2 X F 218-60-4030 Yrs Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location in y 1 XX Yes 2 No Baltimore NA MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygien Department of Health and Mental Hygien I mortant: or items 23a or 28a-faht Important: If item 27 is marked other than "natural", or items 23a or 28a-faht injury or other traumatic event, the Medical Examiner must be notified at once injury or other traumatic event, the Medical Examiner must be notified at once 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 3330 Wilkens Avenue 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. White, etc African Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 4 Divorced 1 Yes 2 X No specify: Specify: American 3 Widowed f Yes, Give Year ğ 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Domestic Compl 12th Grade NA Home maker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mae Montgomery Willie Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 Braddish Avenue Baltimore, Maryland 21216 Helen Parnell-Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 08-21-12 Baltimore, MD. Trinity Cemetery 4 Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service Licenses Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 Approximate Interval Between Onset and Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** (Madical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. If any, leading to immedia Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED23a,pt.II,27,per me,g930 8-29-12 sm **X** UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year Live birth 2 Fetal death 3 Ectopic pregnancy Month Day past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte I be detached for 1 1 Yes 2 V No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Yes 2 No 3 Probably 4 V Unknown Chronic Obstructive Pulmonary Disease(COPD), Epilepsy Completed certificate has been a ector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? r this certificate ha ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other: Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After t funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No death. Director: d in by the f 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier 1 [ CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. August 16, 2012 Name and address of person who completed of use of death (Item 23a)

State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

gistrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20<sup>Year</sup>2 Awonth 1:02A Timothy Joseph Cooke Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospice Dove House Westminster 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** Days (Month, Day, Year) Director 219-66-3545 1 M 2 □ F 11/30/1955 56 MD i and 2 should be filed within 72 nows and fleath and Mental Hygiene.
If Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Carroll 1 Yes 2 No Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 48 Goni Terrace 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Namied þ 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Secondary (0-12) Fork Lift Operator Distribution Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert J. Cooke Rosemary E. Brady 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy S. Cooke-wife 48 Goni Terrace, Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State Meadow Branch 8/27/12 Westminster 4 Donation 5 Other (Specify) 21. Signature of 22. Name and Address of Facilit Fletcher Funeral Home Service Licenses ome, P 21157 Main St., Westminster, MD 23a. Part 1. Enter the shock, or heart sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or repairatory are Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physicien and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director After this certificate has been signed by the attending physician and mipletely filler in by the Internal director, page 2 should be detached for use as the burial-transity. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 ☐ No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) INVATIEN |은 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 🗹 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signatu 29d. Date signed (Month. Day, Year) lame and 5

Registrar

State

31. Date filed (Month, Day, Year,

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 7:30 PM RUTHE CHARLOW August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 212-30-8470 **Director** 1 🗆 M 2 🗓 F 79 02/28/1933 **GERMANY** Usual Residence of Deced show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 ☐ Yes 2 🔀 No MD BALTIMORE BALTIMORE 10e. Street and Numb 10f. Zip Code ò 10g. Citizen of What Country? 23a 628 KAHN DRIVE 21208 USA or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. injury or other traumatic event, the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 X Widowed 4 Divorced Completed Year or Dates CHAR $\mathcal{L} \mathcal{O} \mathcal{N}$ . R $\mathcal{L} \mathcal{L} \mathcal{N}$ 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) marked 2 KURT PESE ALICE ROSENBERG and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other traionce, CRAIG CHARLOW / SON 2932 ST PAUL STREET, BALTIMORE, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 ANSHE EMUNAH CEMETERY 08/22/2012 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical **Examiner** colon So wentially list a mality as if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 Yes 2 No Month Pregnant at time of death Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ renal Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 2 1 No this certificate Yes 2 No 1 🗆 Yes or Attending Physician: 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☐ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending ☐ Accident Investigation 1 Yes 2 No the

State Registrar

DHMH 17 Rev 06-2011

Hospital

filled in by

3 ☐ Suicide 4 ☐ Homicide

29a. Certifier

6 Could not be

miner

C. SUPIAND

determined

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00051347

Baltimore MD 21204

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6701 N. Charles St

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

mend #1 Per PHY&#5 &8 Per ANA BD G931 9/17/2012 Jh

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Charles Lee DuDonis Physician/ U9US Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** REGIONAL Jessu WN INTIRMAR Security Numbel If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Det 08 - 1944 **Funeral** Months Days 1 🗷 M 2 🗆 F Hours 62 67 Maryland 212-42-5612 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🙀 No Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20794 7800 House of Corrections Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 filed within 72 hours after White 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation UN (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jean Michocki William DuDonis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2301 Fife Ct; Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print) Jean Thompson - sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4  $\square$  Donation 5  $\square$  Other (Specify) in state cemetery, crematory or other place) Specing Signature 21. Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final) Approximate Interval Between Onset and Death Hepa Pnysician/ to month disease or condition resulting in death) Medical Due to fr as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a consequence of) it any, leading to infriediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filied in by the funeral director, page 2 should be detached for use as the burlar-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 1 Yes 2 g 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA ျု 27. Manner of Death 28a, Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No iniury 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [ only one 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 20-30. Name and address of person who completed cause of death (Item 28a) (T 0 00

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

**AUG 2 4** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Kumar Dass 2012 D. 10:10 PM August Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 30, 1939 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1**X** M 2 □ F **Director** 069-50-4202 72 India Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director MD 1 ☐ Yes 2X No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9607 Armistead Rd. 20903 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian med Force Black, White, etc. 1 Never Married 2 X Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Asian Indian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Sales / Repair Office Equipment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Demig Dass Bhaijee Maniben or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Snehalata Dass / Wife 9607 Armistead Rd., Silver Spring, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Date 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08/25/2012 Burtonsville, MD 22. Name and Address of Facility
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cell Carcinoma Physician/ Syvamous disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner one week Aspiration pheumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trans that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Day Pregnant at time of death Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Coronary Artery Dicease 1 Yes 2 No 3 Probably 4 Unknown Completed Diabetes mellitus, Type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 **X**No Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur of certifie 29d. Date signed (Month, Day, Year) August D61007 19 2012

Registrar
DHMH 17 Rev 7/2009

State

12520 PROSPERITY DR #320

CILVER SPRING

MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHANDAGLE

State of Maryland / Department of Health and Mental Hyglene    Consideration   Contribution   Co				Please 1	State of Ma							-		_	le.		
Decided Name   Proceedings   Decided Name   Decide Name   Decided Name   Decide Nam				1 _ State	State of Ma	ryland /					and IV			0.0	1 2	27	022
Description							Oci	incai	e or L	Catri				°. 2 U	1	3 Time c	of Death
## Further   130.2 Pennsylvania Avenue Apt. #7   State   State				Johnny Curt	tis De	Vone						Month	Da				
Second Second Plane   Total Control   Total	jar							4b. City,	Town, or	Location of	of Death	Aug.		,	-OIZ		<u> </u>
The control of the case   Characteristic   Characteristic	Seaton	/		1302 Pennsylvani						ore_					NA		
The State of Control o					3-		thday)					8. Date of Birt	th y, <u>Ye<i>a</i></u> r)	9		rv)	or Foreign
Physician  Physician  Medical  Examiner  Physician  Medical  Examiner  Fig. 23a. Part i. Enter the disease, or complications that chelled the death, Do not enter the mode of dying, such as on guillact or respiratory arest.  Approximate frierwill Between respiratory arest.  But to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a conse					&M 2 LJ F	54	Yrs.					10-05-	-5/			MD	
Physician  Physician  Medical  Examiner  Physician  Medical  Examiner  Fig. 23a. Part i. Enter the disease, or complications that chelled the death, Do not enter the mode of dying, such as on guillact or respiratory arest.  Approximate frierwill Between respiratory arest.  But to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a conse		land show	to	10a. State 10b. County		10c. City, Tow	n or Lo	cation							1	0d. Inside C	City Limits
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Dec: Johnny C. DeVone

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 August Claudia Lynn Dailey 8:25 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 12203 Maycheck Lane Prince George's Bowie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🟋 F Months Hours May 31 .1<u>943</u> Director 69 Yrs. Florida 579-56-2290 Usual Residence of Decedent show init. Page 1 and 2 should be filed within 72 hours after death with the Maryland astiment of Health and Mental Hygiene. Nortant: If item 27 is marked other than "natural", or items 23a or 28a-f shor injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Prince George's Bowie 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12203 Maycheck Lane 20715 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 🗌 Yes 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 X Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Dog Groomer Pet Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fitzgerre1 Frank Lorraine Alice Kingman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Physician. Medical Examiner

permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once.

Helen T. Roberson /

20a. Method of Disposition

30. Name and address of pe

AUG 24 2012

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Division of Vital Records, P.O. Box 68760

the Hospital or Attending Physician:

	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 😿 Donation 5 ☐ Other (Specif		cemetery, cre Uniforme	matory or other place d Sers. Ui	) niv. 08/		Bethes	
	21. Signature of Funeral Service Ligary	man mod	382 R	2. Name and Address app Funera 33 Gist Av	of Facility of Core., Sil	remation ver Spri	Services	0910
	23a. Part 1. Effer the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. $\overline{ ext{LI}}$	ver cance  VER cance  consequence of):		such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death MONTHS
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2▼ No 9 ☐ Unknown	23c. If yes, outcome of 1  Live Birth 2 4  Pregnant at t 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
ted by P	Part II. Other significant conditions co	ontributing to death but	not resulting in the I	underlying cause give	n in Part I.		acco use contribute to	o the cause of death?  Probably 4 Unknown
Comple		-				24a. Was an autopsy perform 1 \(\sum \) Yes 2	prior to death?	utopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?			26. Plac	e of Death (Chec	k only one)		
	1 ☐ Yes 2X No	Hospital:	2 ER/Outpatie	nt 3 DOA Other	4 Nursing H	ome 5 X Resider	nce 6 Other (Spec	cifu)
Medical Certificate: To	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, )	v injury occurred					
al Certi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, str Specify)	eet and Number or Ru State)	t and Number or Rural Route Number, tate)			
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	29b. Signature and title of certifier			29c. License r	number	29	d. Date signed (Mont	h, Day, Year)

D19431

11701 LIVINGSTON RD., FT. WASHINGTON, MD

12203 Maycheck Lane, Bowie, MD

Date

20c. Location - City or Town, State

AUGUST 22, 2012

20744

DHMH 17 Rev 7/2009

State

Registrar

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ EICHELBERGER 1047 AM Medical 4b. City, Town, or Location of Death BALTIMURE 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death AGNES If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 214-20-8335 90 **Director** 1 M 2 F 06/15/1922 CAROLINA 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 🗆 Yes 2 📉 GWYNN OAK ö 10g. Citizen of What Country? Funeral items 23a U.S.A 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. "natural", or iten edical Examiner r 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK 3 ★ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE NURSING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o မ permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked WHITE THOMAS OLIVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RichField VAldeitha CA DR. SEVERN, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) on Cemetery (28/2012 BAltimore, MARYLAND 22. Name and Address of Facility & DERRICK C. JONES FIH, P.A. Burial 2 Cremation 3 Removal from State injury or Woodlawn Cemeters 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service any ir 4611 PARK 1+945. AVE., BAILIMORE, MARVIANA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. iterval Between inset and Death Immediate Cause (Final Physician/ ACUTE MY OCARDIAL disease or condition resulting in death) INFARCTION 204 V Medical Examiner 4-ears ORONARY Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months Day Pregnant at time of death Year 2 No Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ISCHEMIC CARDIOMYOPATITY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown pege 2 should DEEP VEIN THROMBOSIS Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 2 🗌 No Yes 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Mann of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Matural 5 Pending injury 2 Accident
3 Suice 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 22648 AUGUST 22,2012 Vm Q

DHMH 17 Rev 06-2011

State Registrar

EICHEL BERGER

SNYDER MID. 900 SOUTH CATON AVENUE BALTIMORE, MARKAND

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

JEROME I

Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

iane Edwards		I- For State Registrar	Sta	ate of M	aryland		artment o <i>rtificate o</i> i			Ment	al Hyg		g. No.	20	12	2	703
Physician	1	1. Decedent's Name				*						Date of Deat	h Dav	Year	3.	Time of	
redical Examine		T Diane Edwards  August 17, 2012  4a. Facility Name (if not institution, give street and number)  August 17, 2012  4b. City, Town, or Location of Death  4c. County of Death										eath	0033	nrs			
1		Johns Hopk				,		Baltir						N/A			
Funeral Director	- 1	5. Social Security N 212-70-6		6. Sex 7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY)   Months   Days   Hours   Min.   0 9 / 0 4 / 1 9 5 8									E	reign	lace (Sta		
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Baltimore, bermit. Pages 1 at Department of He Important: If ite	Į	4 Donation 5	Other Sp	ecify:		on	-site		_		_					, MD	
Balt permit Depart Impor injury	1	21. Signature of Fur	neral Service	Licenson	Kon	7001						r. Fui ve., I				PA	
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D. Box 6876; the death certificat by the attending physical by the attending physical by the attending physical by the attending physical by the for use as the physical physi	200	1 Yes 2 N	lo 9 🗹 Unk	nown 4 5	Pregnant a Unknown	t time of de	eath 5 Ot	her (Spe	cify)				4				
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n of Viing Physical differential differentia		27. Manner of Death			a. Date of Inj (Month, Day, ug 17, 2012	ury (ear)	28b. Time of I	njury		at Work?	بروا	d. Describe h ibject shot		occurred	-		
Division al or Attendii rs after death. al Director: /		2 Accident	5 Pend Inves	tigation			ome, farm, stre	at factor		es 2 🗸 l	¥0	f. Location (S		Number	- Oural	Doubs No	umb os Citu
Division or spiral or Attending, hours after death.  neral Director: After y filled in by the fune.		3  Suicide 4 ✓ Homicide		norbe	pecify) Lo			et, lactory	, office bu	mariy, etc.		or Town, St 00 Hamilton	ate)				amber, City
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F wit	Be	29b. Signature and	title of certifie		anner stated	1		290	c. License	number			29d. Dat	te signed (	Month,	Day, Yea	ar)
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2		30. Name and addre Melissa Bra					123a) ner 900 W	/. Baltin	nore Str	reet. Ba	ltimore.	MD 2122	3				
Stat	te	31. Date filed (Mont			32. Kegistra	ar's Signatu	-	Na									
Registra	ar	A	UG 24	2012	Gener	~ /	. 7										

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#30perDVR, G930, 8/24/2012 WS State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ames Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City, Town, or Location of Death 4c. County of Death OKINS Baltimore Johns to N/A If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number 5 0 Days Hours Director 1 € M 2 □ F 55 02/12/1957 Maryland ence of Decedent r then "naturel", or items 23a or 28e-f show the Wedlcal Evaniner must be notified at 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zîp Code 10g, Citizen of What Country? Funeral 1915 W. Lanvale St. 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. "naturel", or ð 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 I th and Mental Hyglene, ?**7 is marked other then "r** 1 Elementary/Secondary (0-12) College (1-4 or 5+) Construction Contractors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Luther White Lena Foye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr Department of Heelth an Importent: If Item 27 is eny Injury or other treui once. Ethel White(Sister) 706 N. Linwood Ave., Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 8-23-12 on-site Crematory 4 Denation 5 Other (Specify) Baltimore, MD Signature of uneral Service Licer <sup>22</sup>Josephor Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 100 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pulmonary Physic and Fibrosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Due to (or as a consequence of): signed by the attending physician end d be detached for use as the burlal-transit Hospital or Attending Physiclan; The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) Month 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? is certificate has been si director, pege 2 should I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🖢 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ in 24 hours efter death, he Funeral Director: After this on noletely filled in by the funeral dif-1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arun Jose M.D. JOhns Hopkins Hospital Baltimore, MARYLAND 31. Date filed (Month, Day, Year)
AIIG 2 4 2012 32. Registrar's Signature State AUG 24 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FIKE Physician/ 5:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll County General Hospital Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 293.44-1004 **Director** 1 M 2 D F 63 Feb. 10,1949 Pennsylvania Usual Residence of Decedent th and Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner m<u>ust be notified at</u> 10c. City, Town or Location 10d. Inside City Limits Director Marvland Union Bridge 1 Yes 2 🕅 No Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 E. Elger St., Apt. 2B, P.O. Box 531 21791 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 T No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ison Fike Shandor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si of Health a item 27 i Ellen Drohomirecky / Sister 110 E. Commercial St., Ozark, Arkansas 72949 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of timportant: If its eny injury or of once. 1 Durial 2 Dremation 3 Removal from State Metro Crematory Inc. 08/23/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Alyson K 22. Name and Address of Facility Cremation Society of Maryland Inc Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. ther the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ACUTE Physician/ disease or condition resulting in death) Medical Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transif Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached to 9 Unknown 9 Unknown <u>P</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE PULMONARY Records, 1 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☑ No \_2 🔽 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier Doo17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL HOSPITAL CENTER, WESTMINSTER, MD 21157 ABDALLAH J. HELOU, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4 uqust 11:30A FRIDMAN SAMUEL Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Hospital of Baltimore Baltimore Cita N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** UKRAINE 12/15/1925 Director 216-25-6599 86 1 **X** M 2 □ F Usual Residence of Decedent ir than "natural", or Itams 23a or 28s-f show the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director OWINGS MILLS BALTIMORE MD 1 🗌 Yes 2 🌠 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ÚSA Funeral 21117 3414 ASSOCIATED WAY, #224 I Hygiene. othar than "natural", or Itams death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Race - American Indian. Armed Forces? Black White etc. \$ 1 Never Married 2 Married hours efter Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Yes, Give Specify 3 ⅓ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION **TEACHER** 5 +Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ABRAM FRIDMAN UNKNOWN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 FOX CREEK COURT, OWINGS MILLS, MD 21117 19a. Informant's Name/Relationship (Type, Print) ALEXANDER FRIEDMAN/SON Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 08/19/2012 OWINGS MILLS, MD 4 Donation 5 Other (Specify) SOL LEVINSON & BROS., INC. 21. Sign aura of Funeral Service License 22. Name and Address of Facility richall 8900 REISTERSTOWN ROAD , PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemic Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami attending physician end for use es the burial-trensit Hospitallor Attending Physician: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day ed by the a Division of Vital Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonary Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate Yes 2 No 1 🗌 Yes director, æ 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 D Natural work?
1 Yes 2 No 5 Pending inferdeath.
Director Afficial by the full 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours of To the Funaral Discompletely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier RES-000 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave. Baltmore MD 21215 Nagendra Madisi 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

AUG 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 1994 2012 12:35 Am Lillian George Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Gilchrist Hospice, Inc. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) 79 Director 248-56-5324 1 M 2 X F 1932 South Carolina 18, Usual Residence of Decede ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21046 USA 10083 Hatbrim Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☒ No Specify. Specify Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) teaching education Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy important: If Item 27 is marked oth any injury or other traumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Allie-Bess Timmons Eddie Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3311 Rhode Island Ave #210; Mt. Rainier, MD 20712 Toni Lynn George - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board of Pureral Service Litenses Ronald S Director 655 W. Baltimore St; Baltimore, MD 21201 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ OUAVIAN disease or condition Medical resulting in death) Due to (or as a consequence of) . Examiner Sequentially list conditions, Examine if any, leading to immediate cause End of Loverbying Cause (Disease or injury that initiated events Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Tes 2 🗗 No 욘 Dice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completely fil 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Mem 23a) (Type, Print) Charles St.

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2012

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #11 per FH G930 8/24/2012 JH. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10205P M DONALD GREBOS JOSEPH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) Days 219-32-0529 **Director** 1 🕅 M 2 🗆 F 74 11/05/1937 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD ANNE ARUNDEL MILLERSVILLE 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 8 ROL PARK TRAILER VILLAGE 21108 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 🎇 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE ⊕ Widowed XX Divorced Completed I Hygiene. other than "natur vent, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NURSING ASSISTANT n and Mental Hygier SPECIAL NEEDS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ 27 is marked r traumatic e UNKNOWN UNKNOWN UNKNOWN permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic onee. GREBOS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNA KAY/DAUGHTER 3609 TENTH STREET, BALTIMORE, MD 21125 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) HILLTOP SERVICE CORP. 08/21/2012 TOWSON, MD Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. May 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate Yes To the Hospital or Attending Physician: Twithin 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 1 \( \text{Yes} \) 2 \( \text{No} \) 5 Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to only one) Signature and tir 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WUSU-BOR

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

2

Kenneth Lawrence		Department of Health a Certificate of Death	nd Mental Hygiene	Reg. No. 2012 2704
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)		2. Date of De Month August 2	
	4a. Facility Name (if not institution, give street and number) 8438 CoCo Road	4b. City, Town, Rosedale	or Location of Death	4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 7. Age (In 220-94-0855 1) 7. Age (In 2 1	n yrs. last birthday) If Under 1 Y 45 Yrs. Months		irth(MM/DD/YYYY) 9. Birthplace (State or 2, 1966 Country) Maryland
Maryland 28s-f show any 1.81 once, ector	Usual Residence of Decedent  10a. State 10b. County 10c  Maryland Baltimore	c. City, Town or Location Rosedale		10d, Inside City Limits 1 Yes 2 X No
the Maryland a or 28a-f sh utified at once	10e. Street and Number 8438 Coco Road	10f. Zip Cod 21237		10g. Citizen of What Country?  USA
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  Int: Witem 37 is marked other than "natural", or items 33a or 28a-fahor rother traumatic event, the Medical Examiner must be notified at once,  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married Armed Forces?  3 Widowed 4 Divorced If Yes, Give Year or Dates:	No 1 Yes 2 X		o- 14. Race - American Indian, Black, White, etc. White Specify:
, MD 21215-0036 and 2 should be filed within 72 hours after tealth and Mental Hygiene. frem 27 is marked other than "natural", traumatic event, the Medical Examiner To Be Completed by I	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12) College (1-4 or 5+)  12	16a. Decedent's Usual Occuduring most of working  Disable		16b. Kind of Business/Industry  N/A
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than mastic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last)  Joseph Gray		18.Mother's Name (First, Middle, Alma Smith	
MD 21 and 2 should alth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print)  `Lisa Marie Gray / Wife			mber, City or Town, State, Zip Code) 21237
Baltimore, ME permit Pages I and 2 s Department of Health a Important: Witen 27 injury or other traum:	20a. Method of Disposition  1	20b. Place of Disposition (Name of crematory or other place) Gardens Of Fait	8/27/12	20c. Location - City or Town, State Baltimore MD
	At 4 Hollo	5305 Har	ss of Facility J. Ruck, Inc. Ford Road Baltim	
Physician Examiner	23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.      Immediate Cause (Final disease or condition resulting in death)      Due to (or as a consequence)	tinal Hemorrhage	g, such as cardiac or respiratory ar	rest, shock, or heart Approximate Interval Between Onset and Death
e executed cian and rial - transit	Sequentially list conditions, if any leading to infraedate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of the co	eal Varices		
be executed ician and urial - transit	d. UNPENDED AMENDED			
Division of Vital Records, P.O. Box 68760, to the Hospital nr Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Completed by Physician/Medical Es	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fetal death	Ectopic pregnancy	23d. Date of delivery  Month Day Year
S, P.O. E quires that the can signed by the old be detached the can be detached the	Part II. Other significant conditions contributing to death bu	t not resulting in the underlying caus	1 Ye	tobacco use contribute to the cause of death?
Division of Vital Records, tal maratending Physician: The law requires rs after death.  at Director: After this certificate has been signed in by the funeral director, page 2 should be setfification: To Be Completed			1 <b>✓</b> Yes	
F Vital Rec Physician: The rr this certificate ral director, page To Be Con	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient		ce of Death (Check only one)  Other   Nursing Home   5	Residence 6 🗸 Other: Scene
Division of Nours after data.  Division of Nours after death.  Beral Director: After tiffled in by the funeral Certification: T	27. Manner of Death  1 ✓ Natural 5 Pending 2 Accident Investigation	1	Yes 2 No	how injury occurred
Divis  Septial or A  hours after  neeral Dire  y filled in b	4 Homicide determined (Specify)	- At home, farm, street, factory, offic	building, etc. 28f. Location ( or Town, s	(Street and Number or Rural Route Number, City State)
To the Hos within 24 h To the Fur completely	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examine and manner stated.	ation and/or investigation, in my opin	on, death occurred at the time, date	
<b>D</b>	29b. Signature and title of certifier  Car of Hillar		nse number	29d. Date signed (Month, Day, Year) August 22, 2012
<b>t</b>		niner 900 W. Baltimore S	reet, Baltimore, MD 21223	
State Registrar		Signature		
DHMH 17 Rev 1/2001 OCME 2006	OCME	ORIGINAL		

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year Carroll E. Hickey 9:30 PM Medical 22 August 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Stella Maris</u> Timonium Baltimore 6. Sex . Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Days Months Hours 213-70-4491 1 🏅 M 2 🗆 F 54 Director Yrs 03-12-1958 Maryland Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Dunda1k 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3123 Sollers Point Road United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner I 14. Race - American Indian, Black, White, etc. Armed Forces by 1 Never Married 2X Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Beer Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard L. Hickey Eileen Mueller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon K. Hickey (Wife) 3123 Sollers Point Road Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) sacred Ht of Jesus 08-25-2012 Dundalk, Maryland 21. Signature of Fun val Service Lio, nsee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Avenue Dundalk, Md. 21222 Inc. scott P. Gardner 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence oi). that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Rocords, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate l Hospital or Attending Physician: The 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 **X** No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending injury М 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

TRACIE L. MORGAN,

31. Date filed (Month, Day, Year)

CRNP

32. Registrar's Signature

2012

AUGUST

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lawrence Sylvester Hammond M8th P8 5:55P 20°12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Joseph Richev Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Days (Month, Day, Year) unk Director 1 □XM 2 □ F 83 02/08/1929 Maryland Usual Residence of Deceden Hammonc 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23e or 28e-f sho the Medical Examiner must be notified at Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2230 Ruskin Ave. 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married Maryland 21215-0036 Š 1 ☐ Yes 2X No If Yes, Give 1 ☐ Yes 24 ☐ No Specify. Specify. Completed 3 XWidowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiana. marked other than entary/Secondary (0-12) h Grade College (1-4 or 5+) Window Cleaner At Once CLeaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba file and Mental H ဥ Unk Helen Hammond 19a. Informant's Name/Relationship (Type, Print) (Grand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3806 Pall Mall Rd., Baltimore, MD 21215 parmit, Pega 1 and 2 sh Dapertmant of Haelth ar Important: if item 27 is eny injury or other trau 80 Shannon Lane-Harris(Child) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State Zion Cem. 08/28/12 Mt. Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) natur of Funeral Service Licenses Forephodes Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death aluna Physiciani disease or condition resulting in death) cancer Medical Due (or as a consequence of): Examiner ardiovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ate has baen signad by the attanding physician end paga 2 should ba detachad for usa es tha burial-trensit <u>Parkinsons</u> that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physicien: The law requires that the death cartificate be within 24 brours after death. To the Funeral Director. After this cartificate has been signed by the attending physicis completally filled in by tha funeral director, page 2 should be detached for use as the bur completally filled in by tha funeral director, page 2 should be detached for use as the bur page 2. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗌 Yes 25. Was case referred to medical Division of Vital æ 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 N Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Camille Menino</u> Joseph Richey Baltimore, Maryland 31. Date filed (Month, Day, Year) AUG 2 4 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 Per PHY C932 10/02/2012 JH State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Shirley Trone Holt Shirley Irene Holt 405us7 Physician/ 2.40A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE Examiner 4b. City, Town, or Location of Death JOSEPH MEDICAL IDWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours Director 1 🗆 M 2 🔀 F 74 09/07/1937 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Co. Pikesville 1 X Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Al-Hannah Cir. 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Completed by 5-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Specify: Black Year or Dates. permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4 or 5+) vears Manager JC Penny Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bill Harris Ruth Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Holt(son) 3907 Noyes Cir., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 8 1 Burial 2 Cremation 3 Removal from State 25-12 4 Donation 5 Other (Specify) on-site Crematory Baltimore, MD 21. Signature Prine al Service Licens 3 Name and Mark of the State of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Onset and Death Immediate Cause (Fi TASTATIC Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No after death.

Director: After this certific
d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes 2 No 28d. Describe how injury occurred Natural 5  $\square$  Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be completely filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29c. License number estesaade MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D DRIVE TOWSON, MD State Registrar

DHMH 17 Rev 06-2011

12-06174 Robert Lee Hardy,		<b>pe or Print in B</b> tate of Maryland						10 0701
	1- For State Registrar	,	Certificate o		,	_	ag. No. 20	12 270
Physician/	1. Decedent's Name (First, Mid-					2. Date of Deat Month	th Day Year	3. Time of Death
Medical Examine	Robert Lee	_		4b. City, Town, or	Leastion of Dooth	Month August 17	, 2012 4c. County of D	0032 hrs
*	Johns Hopkins Bayvi	. •	)	Baltimore	Location of Death		N/A	
Funeral	5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt		. Birthplace (State or
Director	unk	1X M 2 F	33 Yrs	Months Days	Hours Min.	01/05	5/1979 F	oreign Country) M D
= = _	Usual Residence of Decedent			<u> </u>		0.7.00	7,13,73	
w any	10a. State 10b. County		10c. City, Town or Local					10d. Inside City Limits
rland -f shn once.	MD	N/A		Balti	more	The state of the s		
215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a nr 28a-f show ent, the Medical Examiner must be notified at once.  Be Completed by Funeral Director	10e. Street and Number 520 S. Wickl	nam Rd.		10f. Zip Code	229	110	0g. Citizen of What (	
ith th		12. Was Deceden	t Ever in U.S. 13 Wa	as Decedent of His		ecify Yes or No-	U.S.	A • merican Indian, Black,
or death with or items 23 repust be no Funeral	1 X Never Married 2	Married Armed Forces		es, specify Cuban,			White, et	
s after d	3 Widowed 4 Di	vorced If Yes, Give Year or Dates:		Yes 2X No	specify:		Specify:	Black
antura kami	15. Decedent's Education (Sp	ecify only highest grade co	during m	nt's Usual Occupati nost of working life.			16b. Kind of Busine	ess/Industry
36 in 72 i	Elementary/Secondary (0-12	) College (1-4 or	5+)	market			Cunown	a wka +
5-0036 led within 72 hours tygiene. other than "natu tte Medical Exan Completed	17. Father's Name (First, Middle	Last)	Buper		8.Mother's Name (		Superm	arket
21215-0036 mild be filed within 7 Mental Hygiene. marked other than cevent, the Medical for Be Compile	Robert Lee I				Diane		•	
2 5 5 5 5 C	19a Informant's Name/Relation	ship (Type, Print )	19b. Mailin	g Address (Street	and Number or Ru	ural Route Num	ber, City or Town, S	tate, Zip Code)
MD and 2 sho alth and 27 is summati	Robert Lee B	Hardy Sr. (1						
Ore, es la of He If ite	20a. Method of Disposition  1 Burial 2 X Crematic	n 3 Removal from S	20b. Place of Dispos crematory or ot	her place)	- 1	Date	20c. Location - Cit	
Baltimore, permit. Pages I a Department of He Important: If ite	4 Donation 5 Other 8		on-site			21-12		ore, MD
Bal Permi Depar Injur	21. Signature of Funeral Service	ne Joan	ຸ ໃນ 21	oseph H	Brown	Jr. Fu	neral H	ome PA e, MD 2121
Physician	23a. Part I. Enter the disease, of	r complications that caused	d the death. Do not enter t	the mode of dying,	such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interva
Medical	failure. List only one cause Immediate Cause (Final diseas	O	d to Head					Between Onset and Death
Examiner	or condition resulting in death)	Due to (or as a cons						
5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	sequence of):					
i i	cause. Enter Underlying Cause	c						
cecuted and transit	events resulting in death) Last	Due to (or as a cons	sequence of):					
= 25 5		d	_				, .	
ox 68760, auth certificate be ex attending physician for use as the burial sician/Medic	IF FEMALE:	23c. If yes, outco	me of pregnancy				23d. Date of deli	very
68760, certificate be nding physici se as the buri	23b. Was decedent pregnant in past 12 months?	1 Live birth	2 Fe	etal death 3	Ectopic pregnan	су	Month	Day Year
Division of Vital Records, P.O. Box 68760, ral ar Attending Physician: The law requires that the death certificate be exert after death.  **Indirector: After this certificate has been signed by the attending physician a led in by the funeral director, page 2 should be detached for use as the burial—rartification: To Be Completed by Physician/Medica	1 Yes 2 No 9 Ur	nknown 9 Unknown	t time of death 5 Of	ther (Specify)				
cords, P.O. Box law requires that the deatl has been signed by the att 2. Should be detached for polleted by Physi		tions contributing to deat	th but not resulting in the	underlying cause gi	iven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
P.C. res that signed be deter						1 Yes	2 ✓ No 3 🔲	Probably 4 Unknown
rds requi	0					24a. Was a autops		autopsy findings available to completion of cause of
Records, P.O. Box  The law requires that the death ficate has been signed by the atte page 2 should be detached for u  Completed by Physic						perfor	med? deat	h?
of Vital Recing Physician: The Affer this certificate Uneral director, page on: To Be Con			· <u>-</u>		of Death (Check or			
F Vit	1 ✓ Yes 2 No		ent 2 ER/Outpatient				Residence 6 0	ther:
ding I		28a. Date of Inj (Month, Day) Aug 17, 2012	ury 28b. Time of I Year) 0007 hrs			28d. Describe h Subject shot	now injury occurred	
Sio Atten r death ector: by the	2 Accident Inve	estigation 28e Place of I	njury - At home, farm, stre			28f Location (S	Street and Number of	Rural Route Number, City
Divi	3 Suicide 6 Cou 4 ✓ Homicide dete	old not be ermined (Specify) Lo		ot, lactory, office be		or Town, St		
Division Hospital nr Attence 44 hours after death Funeral Director- tely filled in by the	29a. Certifier 1 Certifying F	Physician: To the best of n		rred at the time, dat				
Division of Vital I To the Hospital ar Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director, Medical Certification: To Be (	one) 2 Medical Ex	aminer:On the basis of exa	amination and/or investiga	tion, in my opinion,	death occurred at	the time, date a	and place, and due t	o the cause(s)
F SF S	29b. Signature and title of certifi	er //Sh		29c. License			29d. Date signed	
		rasse 4/ME	5	O.C.N	/I.E.		August 17, 20	12
	30. Name and address of perso		death (Item 23a) Il Examiner 900 W	/ Baltimore St	reet Reltimer	MD 2122	3	
State	Melissa Brassell, MD		ar's Signature	V. Dailinore St	Teer, Daillinore	5, IVIU 2 1 2 2		
Registra		2012 Tener		,,,,,				

DHMH 17 Rev 1/2001 OCME 2006

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20atcor Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month eight prence 0616A M 4 2012 Medical tugu 11 4a. Facility Name (if not institution, give street and number) Examiner 4h Town, or Location of Death 4c. County of Death Balt DKINS tospital More NA **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months Hours Min. Country) Director 212-44-9254 1 🗆 M 2 🖾 F 67 11-10-44 MD or 28a-f show death with the Maryland 10a State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits XX Yes 2 No MD NA Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Items 23a Funeral 2424 Ashland Avenue 21205 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. African 'natural", or à 1 X Never Married 2 Married 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. item 27 is marked other then "natural", or ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Divorced 4 Divorced Completed Specify: American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. City of Baltimore Elementary/Secondary (0-12) College (1-4 or 5+) 4yrs. Paraprofessional 12th Grade School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Myrtle Jenkins Clifton Lloyd Height, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2424 Ashland Avenue Baltimore, Maryland 21205 Garfield Hargrove, Jr.-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Importent: If it
eny Injury or o Pege 1 cemetery, crematory or other place)
King Memorial Park 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/24/2012 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death ₽nysician/ atherosc OVas len disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a nonsecutional crit or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last attending physicien for use es the buris Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy deteched for 5 Other (specify) Month Day 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 1 Yes 2 No Yes 2 - No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မြ Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and close and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2 To the only one) 29b. Signature and title of certifier 29c. License number RES-000 30. Name and address of person on who completed cause of death (Item 23a) (Type, Print) 1800 Orleans St. 32. Registra s Sign State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virginia Nelson Hall 20°T2 1:00A August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll Carroll Lutheran Village Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 227-18-6427 Director 1 M 2 F 2/4/1923 Va 89 28a-f show 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll MD Westminster 10e, Street and Number ò 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with the ntal Hygiene. ed other than "natural", or items 23a or event, the Medical Examiner must be r Funeral United States 21158 250 St. Luke Circle Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify:White Completed 3 N Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 2 should be filed with h and Mental Hygien 7 is marked other th House Wife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lena Victoria Martin injury or other traumatic Carl William Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra 3408 Pleasant Plains Dr., Reisterstown, 21136 Richard Hall-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place South Carroll Crem 8/21/12 Winfield Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home, P.A. 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a conseq Examiner Sequentially list conditions, It any, reading to immediate cause. Enter Underlying Cause (Disease or injury) Examiner ysician and e burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence resulting in death) Last 1Mom 60515 Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 phy: as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Tesidence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death. 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

pleted cause of death (Item 23a) (Type, Print)

51. Luke

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Hamlet Physician/ Clarence 8:50 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town or Location of Death 4c. County of Deat Baltimore Memorial Hospita 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Months (Month. Day, Year, Director 1 M 2 D F Oct. 3 28a-f shov 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Funeral Director Inside City Limits Marvien 1 Ves 2 □ No o 10g. Citizen of What Country? items 23a . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubay, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.

Specify: Black 0 ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", 3 Widowed 4 Divorced If Yes, Give Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT useretired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Elmore Hennella Informant's Name/Relationship (Type, Print) and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra eith Hamlet -50n 710 20a. Method of Dispositiøn 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): physician and the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregna
Prepagant at time of death 5 Other (specify) 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year ed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No Yes 2 Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 🗌 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier assunda 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 909 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cornell Jackson	State of Maryland / Departm 1-For State Certific	nent of Health and Mental Hy cate of Death	ygiene 2012 270	)5
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  CORNELL JACKSO	NNT	2. Date of Death Month Day Year August 18, 2012  3. Time of Death 1730 hrs	
	4a. Facility Name (if not institution, give street and number)  Laurel Regional Hospital	4b. City, Town, or Location of Death Laurel		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last bit 577-96-0280 1 M 2 F 42	rthday)   If Under 1 Year   If Under 24Hrs   Months   Days   Hours   Min.		)C
yland e-f show any Lonce.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  DC Wash	nor Location	10d. Inside City Li	imits
the Maryland s or 28a-f sho riffied at once.	10e. Street and Number 3676 Hayes Street, NE #203	10f. Zip Code	10g. Citizen of What Country?	
her death with the Maryland ", or items 23s or 28s-f sho er must be notified at once. f Funeral Director	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No specify:	pecify Yes or No- 14. Race - American Indian, Black,	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland featth and Mental Hygiene.  tem 27 is marked other than "natural", or items 23s or 28s-f she transmatic event, the Medical Examiner must be notified at once  To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use retined to the control of t		s
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica FO Be Complé	17. Father's Name (First, Middle, Last) Robert E. Jackson		(First, Middle, Maiden Surname) Diane Williams	
MD 21 42 should 11th and Mer a 27 is man unmatic ev	Artina Jackson (wife) 3	676 Hayes St. NE,	Rural Route Number, City or Town, State, Zip Code) #203, Wash. DC 20019	
Baltimore, MD pemit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumating.	1 Burial 2 Cremation 3 Removal from State cremated Donation 5 Other Specify: Harm	of Disposition (Name of cemetery, latory or other place)  Onv Mem. Park   08-	Date 20c. Location - City or Town, State  28-12 Landover, MD	
	21. Signature of Funeral Service Licensee  Terry A. Austin  23a. Part I. Enter the disease, or complications that caused the death. Do r	22. Name and Address of Facility Ro	bbert G. Mason F.H. Rd. SE. Wash. DC 20020	l anual
Physician Wedical Examiner	failure. List only one cause on each line.	Cardiovacsular Diseas	Between Onset	
795	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):			
b, b, b, cician and urial - transit dical Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. C. Due to (or as a consequence of):	-		
	J	me,g931 9-18-12 sm	20d Date of delivery	
D.O. Box 6876i that the death certificate that the death certificate ned by the attending phy detached for use as the t by Physician/Mi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnance 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal death 3 Ectopic pregna 5 Other (Specify)	23d. Date of delivery  Month Day Year	
res that the c signed by the lbe detached d by Ph	Part II. Other significant conditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown	
cords law requi			24a. Was an autopsy performed?  1 V Yes 2 No 1 Yes 2 No 2 N	of
Physician: The string director, page To Be Cor	25. Was case referred to medical examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/0	26.Place of Death (Check Dutpatient 3 DOA Other Nursin	only one)  ng Home 5 Residence 6 Other:	
tending Ph aath. or: After t the funeral		Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
Division of a Division of with the Hospital or Attending Physicial or Attending Physicial 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral Centification: Teledical Centification: T	3 Suicide 6 Could not be determined (Specify)	farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, or Town, State)	City
To the Hosy within 24 ha To the Fun completely	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, done)  2 Medical Examiner: On the basis of examination and/or and manner stated.			
To To Con	29b. Stanature and title of certifier  Augustus	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) August 19, 2012	
( See	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 90	0 W. Baltimore Street, Baltimore, I	MD 21223	
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 4 2012	bares		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:36 PM Physician 2,2012 August largare /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** None Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Yrs. 03/02/1950 **Director** 264-84-5612 NH Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notitled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Howard Laurel 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 10666 Graeloch Road Funeral 20723 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 28 Married 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Alexander Irwin Muriel Scher 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Johnsen - Husband 10666 Graeloch Road Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 XOther (Specific Intombment Meadowridge Mem. 08/27/2012 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intracerebra hemorrhag disease or condition days resulting in death) /Medical Examiner 1ear pertension Sequentially list conditions, if any, leading to infinite rate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the attending physician and ched for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live birth 2  $\square$  Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No this certificate 1 Yes or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 \sum Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural
2 Accident (Month, Day Year) 1 Tes 2 No Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar one)

29b. Signature and title of certifier

Michae

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kornberg

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OTELIA JOHNSON 3:40 AUGUST 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYSLAVIO MEDICAL CENTER 22 SOUTH GREENE STREET.

Social Security Number 6. Sex 7. Age (In yrs. last birth BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Hours 217-64-5974 **Director** 1 M 2 X F 09 124/1956 MD or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director NA 1 X Yes 2 ☐ No Baltimore 10e. Street and Number o ms 23a or must be n 10f. Zip Code 10g, Citizen of What Country? Funeral 323 East 21st. Street 21218 USA permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items:
any injury or other traumatic event, the Medical Examiner mu.
once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. African ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. 3 Widowed 4 Divorced Completed American Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade College (1-4 or 5+) Home maker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Clinton Johnson, Sr. Marion Rlue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Gregory-Daughter 323 E. 21st. Street Baltimore, Maryland 21218 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 08-29-12 Mt. Zion Cem. 4 Donation 5 Other (Specify) Lansdowne, MD 21. Signature of Funeral Service en ee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 23a. Part 1. Enter the disease, or confincations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LEPTOMENINGEAL CARCINOMATOSIS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MONTHS BREAST CANCER METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 as IF FEMALE: for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month signed by the at Id be detached for 1 ☐ Yes 2.49 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Records, Completed 2 No 3 Probably 4 Unknown page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 1 ☐ Yes 2 🗶 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 2 X No 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) 074590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South GREENE St, BALTIMORE. ACH ARYA

DHMH 17 Rev 06-2011

State Registrar 32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0735AM USAMNA Jackson 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomes Medial calv Olney GM Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min 371-22-6926 **Director** 1 🗆 M 2 🗓 F 94 Aug.18,1918 Georgia 28a-f show with the Maryland at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 🗌 Yes 2 🔀 No MD Brookeville Montgomery ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 2511 Owens Road 20833 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 — No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: **Black** 3 X Widowed 4 Divorced Specify: Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than '
traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 8 Laborer Auto Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Susanna Stroud George Phene Goodwin of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Linda S. Stewart-Granddaughter 2511 Owens Road, Brookeville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 № Burial 2 □ Cremation 3 □ Removal from State Elmwood Cemetery 8-28-12 Detroit, Michigan 4 Donation 5 Other (Specify) Metropolitan Funeral Service of Funeral Service Licensee Signatur 22. Name and Address of Facility 5517 Vine Street, Alexandria, VA 22310 Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac mim Medical resulting in death) Due to (or as a consequence of): **Examiner** Weeks Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to or as a conse juence of Advanced Dementio that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 WUnknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform 1 Yes 2 No 2 WN Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1 No 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No injury s after death. Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012

Registrar

DHMH 17 Rev 06-2011

State

18101 Prince Phillip Dr. Olney, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

Brad Justin Pfeffer,

2012

31. Date filed (Month, Day, Year)

AUG 24

		Please Type or Print in Bla State of Maryland					-		_	ble.		
	-	1 - State Registrar		ificate of D				Reg. N		12	270	155
Physicia	_	Decedent's Name (First, Middle, Last)  Jane Lee Ka1b					2. Date of De	D	ay 2	Year 012	3. Time of E	
Medic Examine		4a. Facility Name (if not institution, give street and number)	1.	4b. City, Town, or	Location o	of Death	Augus		c. County o		9:17	A <sup>M</sup>
k. Europald		8006 Old Harford Rd.  5. Social Security Number   6. Sex   7. Age (In yrs. last b	nidhday)	Parkvil If Under 1 Year	1e	24 Hrs. I	8. Date of Bir	th	Balt:			Famian
Funeral Director		212-24-0543 1□M2xF 84		Months Days	Hours	Min.	(Month, Da	ay, Year)		Cour	**	roreign
and show I at	'n	Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Loca	tion			Oct 31	, 15	921		ryland 10d. Inside City	Limits
Maryla 28a-f	irect		kvi11								1 🗌 Yes 2	2X No
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 8006 Old Harford Rd.		10f. Zip Code 21234					Citizen of WI USA	hat Cou	ntry?	
r items		11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	13. Wa	s Decedent of His es, specify Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)			- Americ	can Indian, etc.	
irs after iral", o i Exam	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1 [	Yes 2 No	Specify:				Specify:			
be filed within 72 hours after death with the Maryland and I Hygiene. Ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kir	nt's Usual Occupa ad of work done do NOT use retired)		of workir	ng	16b.	Kind of Bus	siness/In	dustry	
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ld be file Mental I arked o atic eve	2	David C. Price					(First, Middle, ie Sch		n Surname)			
d 2 shou alth and 1 27 is rr er traum		19a. Informant's Name/Relationship (Type, Print) Stephen P. Kalb - son		Address (Street a. 6 01d Ha:								
permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.				tion (Name of tory or other place	e)	С	ate	20c. I	Location - C	City or To	own, State	
permit. F Departm Importal any injur		21. Signature of Funeral Service Licenses Lande Director		Name and Address							21201	
	1	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or head failure. List only one cause on each line.							ore, i		Approximate Interval Between	
Physician/ Medical			ocarc	tral a	Infa	nct	ASE				Onset and De	
Examiner	Je.	Sequentially list conditions,  b. Coronau	S Me	bart	DI	'SE	AST				18 ya	0
cuted nd transit	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	of):		<u>.</u>							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in death) Last  Due to (or as a consequence description of the consequence descript	:e oī):									
certifica ending ph use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal dea	oth 2 🗆 I	Ectopic pregnancy					23d. Date	of deliv	ery	
he death y the atte sched for	hysici	in the past 12 months?  1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Other (specify)					Mont	th	Day Ye.	ar
res that t signed b d be deta	2	Part II. Other significant conditions contributing to death but not resulting to death but not resulti			en in Part I.						he cause of dea	
w requi	Completed	Bladder Cancer					24a. Was	an	24b. We	ere auto	psy findings av	ailable
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rsician; s certifii director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Outpationt	Other	ce of Deat				o Outra	(016		
ling Phy  ∆fter this funeral c		27. Manner of Death  1 Natural 5 □ Pending  28a. Date of injury (Month, Day, Year)	o. Time of injury	28c. Injury work?	at	2	ne 5 Resi				2	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	2	farm, stree		Yes 2	$\rightarrow$	28f. Location ( City or To			or Rura	l Route Number	r,
spital o		29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death oc	curred at the time,	date and	place, an				r as stat	ed.	
the Ho hin 24 I the Fu	Medical	(Check 2 Hedical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practitioner: To the best of my kn	d/or investig	ation, in my opinior eath occurred at th	n, death oci e time, dati	curred at	the time, date	and plac	e, and due t	o the ca	use(s) and mann	ner stated
vitl To		29b. Signature and title of certifier  Mana 4		29c. License	50	15		1	ate signed ( $620$		Day, Year) 20/2	2
		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Prin	nt) A		M						
State Registra	_	31. Date filed (Month, Day, Year)  AUG 2 4 2012	Sar	W)							-	
		NULL A TOTAL PARTY OF THE PARTY	11									

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month RUDOLPH KAPUSCINSKI UGUST 23,2012 5:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4711 WOODLEA AVENUE BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8 Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Days Director 212-30-9173 1 XM 2 AF 78 MARYLAND AUGUST 6,1934 iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director MD. N/A BALTIMORE 1 Xes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **4711 WOODLEA AVENUE** 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 🗖 Yes 2 ☐ No If Yes, Give 1961—1963 Year or Dates. Maryland 21215-0036 1 Yes 2 X No WHITE "natural", Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 CRANE OPERATOR UNION LOCAL 37 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be HARRY ROSS **ELEANOR KAPUSCINSKI** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SPOUSE MARY L. KAPUSCINSKI **4711 WOODLEA AVENUE** BALTO.MD. 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CROWNSVILLE VETERAN 8-28-2012 CROWNSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 6415 BELAIR ROAD BALTO.MD. 21206 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on anothing Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury nding physician and use as the burial-transit Exami RINA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atter d be detached for a in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate hes been sir funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA in by the funeral 28a. Date of injury (Month, Day, Year) 27. Mann Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No i or Attend after death Director: A Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours aff To the Funeral Dis completely filled in Medical Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

0

DHMH 17 Rev 06-2011

only one) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:08AM emper 012 Medical ugu 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Randallstown North west Hospita Center BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 214-01-4124 1 🗆 M 2 🛛 F 93 01/12/1919 MD Usual Residence of Decedent or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumetic event, the Medical Examiner must be notified at Director BALTIMORE PIKESVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or iteme 23a Funeral 1 SLADE AVENUE, #306 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Important: If Item 27 is merked other than any injury or other treumetic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BENJAMIN HAMENT CARRIE SUSSMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD KEMPER / SON 8304 BURNING WOOD ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 08/23/2012 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of: disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine sate has been signed by the attending physiclan and page 2 should be detached for use as the burlal-transit Hospitai or Attending Physician: The law requires that the death certificate be executed Health care acquired pheumonia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ atrial fibrillation, Completed 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Kidney disease 24a. Was an Chronic autopsy performed? Yes 2 N Anemia ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes Other: ပ္ 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this s 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completely filled in by the funer 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar Joslon

4

Boston

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

North west

32. Registrar's Signature

Haspital

28462

Center

Randallstown

ANNIE 08 2012 LITTLEJOHN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 🖳 F Vrs **Director** 579-64-1351 5-12-1948 Wash. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any filury or other traumatic exercises. 10a. State 10b. County 10c. City, Town or Location Director MD PG Landoyer 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6905 Forest Terrace 20617 US Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1€ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes Ž ☐ No Specify. ò Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Copywriter Library of Congress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Littlejohn Georgia Taylor ္ဝ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Wilson (sister) 8901 Owens Way, Brandywine, MD 20613 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Cheltenham MD Vet | 08-20-12 Cheltenham, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert G. Mason F.H. 21. Signature of Funeral Service Licensee Prerry A. Austin 1661 Good Hope Rd. SE, Wash, DC 20020 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cerebrovascular Accident **Physician** /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Hypertension Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy **2**√2¥No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

Reg. No.

Day

Year

10:00

DC

10d. Inside City Limits 1√2 Yes 2 □ No

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

08-12-2012

Year

2. Date of Death Month

amend #30, Per FH G930 8/24/2012 JH State of Maryland Department of Health and Mental Hygiene

1. Decedent's Name (First, Middle, Last)

Physician

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifie

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kanwalit Kaur Nagi Holy Cross Hospital Silver Spring, Md

32. Registrar's Sgnature

29c. License number

D560<sub>63</sub>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar State of Maryland /	Department of Health and M  Certificate of Death	lental Hygiene
Physician/ Medical	1. Decedent's Name (First, Middle, Last)  Marcheta L. Lawrence		2. Date of Death Month Day Year August 22 2012 10:15 p M
Examiner	4a. Facility Name (if not institution, give street and number) Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring	4c. County of Death  Montgomery
Funeral Director	5. Social Security Number  319–24–6005  Usual Residence of Decedent  6. Sex  1	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 03/25/1930  9. Birthplace (State or Foreign Country) Wisconsin
ne Maryland or 28a-f show notified at			10d. Inside City Limits 1 ☐ Yes 2 🙀 No
leath with the terms 23a or er must be n	3148 Gracefield Road Apt. CL622	10f. Zip Code 20904–5866	10g. Citizen of What Country?  United States
0 2.9	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☒ No   If Yes, Give   Year or Dates.	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	ify Yes or No- lican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036 within 72 hours after giene. the Medical Exam completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  5-1	Decedent's Usual Occupation (Give kind of work done during most of workin, life. DO NOT use retired)  Librarian	
Maryland 2 2 should be filed with and Mental Hygica Tis marked other traumatic event, t	17. Father's Name (First, Middle, Last)  Clarence Hoke	18. Mother's Name	Library (First, Middle, Maiden Surname) Sinnett
e, Mary and 2 should fealth and h ym 27 is me her trauma	Kaye L. Pelovitz - Daughter	p. Mailing Address (Street and Number or Rural 10801 Symphony Way Co	
imo Page nent c	1 Burial 2 Cremation 3 Removal from State cemeter	ry, crematory or other place) tion Center of MD 08/2	
Balti permit. Depart Importa any inju	23a. Part 1. Enter the disease, or complications that caused the death. Do	4112 Old Columbia P	y H. Witzke's Family FH Inc. ike Ellicott City, MD 21043 respiratory arrest,  Approximate
Physicia Medical Examiner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Congestive Heart Due to (or as a consequence		Interval Between Onset and Death
kecuted and al-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Atherosclerotic bue to (or as a consequence cause (Disease or injury that initiated events resulting in death) Last  c. Due to (or as a consequence d.		ase Years
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hour after death. To the Funeral Director After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burit Medical Certificate: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3  Ectopic pregnancy 5  Other (specify)	23d. Date of delivery  Month Day Year
rds, P.C. squires that the seen signed be could be detailed by P.C. steed by P.C. stee	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
Records, n: The law requires ficate has been sign; page 2 should t	25. Was case referred to medical		24a. Was an autopsy performed?  1  Yes 2  No 1  Yes 2  No 24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No 1  Yes 2  No
ivision of Vital or Attending Physician: after death. Director After this certific d in by the funeral director Certificate: To Be	examiner?  1	F: (	e 5 Residence 6 Other (Specify)  dd. Describe how injury occurred
Division after de are Directo	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		3f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital within 24 hour a To the Funeral Ecompletely filled	29a. Certifier (Check only one)  29b. Signature and the original configuration and the c	r investigation, in my opinion, death occurred at the	se time, date and place, and due to the cause(s) and manner stated
	30. Name and address of person who completed cause of death (Item 23a) (	24035	August 23, 2012
State		field Road Silver Spi	ring, MD 20904
Registrar  DHMH 17 Rev 06-2011	AUG 2 4 2012  32. Fegistrar's Signature	gave	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ▲ Month OIZea ux 11/4 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hopkins Balt marc Johns Itospital N/A 8. Date of Birth (Month, Day, Year) May 13, 1981 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Days Min 214-17-7197 Director 1 □ M 2 🕅 F 31 Usual Residence of Deceden r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. so ther than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 723 South Montford Avenue 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Student Education permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other tany injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Douglas Κ. Loizeaux Garson Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas K. Loizeaux Father 2737 Stillhaven Court Phoenix, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Decremation 3 Removal from State Hilltop Service Corp | 8-24-2012 Towson Maryland 4 Donation 5 Other (Specify) 21. Signature of France Service Livensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a or sequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 Pregnant at time of death 9 Unknown 5 Other (specify) Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ျှ Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 Tes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital of 24 hours a Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one 29b. Signature and title of certifier nd address of person who completed cause of death (Item 23a) (Type, Print) 1800 Orleanst Bha<u>rati</u> 21/18 31. Date filed (Month, Day, Year) AUG 2 4 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2 Date of Deat Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number 6 Sex 7. Age (In vrs. last birthday) Days Hours Director 214-66-6668 1XXM 2 □ F 57 Yrs. Jun. 22, 1955 MD permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner must be an once.</u> 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XXVo MD Carroll Hampstead 10e. Street and Number 10g. Citizen of What Country? Funeral 21074 4626 Marksman Ct. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1/XYes 2 □ No 1976-Black, White, etc. 1XX Never Married 2 Married Completed by 1 Yes 2XXNo Specify. 3 Widowed 4 Divorced If Yes, Give Specify: 1982 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Plumber Smith Mechanical æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Douglas Howard Marriott, Sr. Mildred Lee Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4626 Marksman Ct. Hampstead, MD 21074 Sharon L. Spencer (Sister) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date All Faiths Crematory & Chapel 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 8/24/2012 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Şigirature of Fun al Service Licen 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Dr. Manchester, MD 21102 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ (uncer disease or condition resulting in death) LUNG Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): signed by the attending physician end d be detached for use as the burlal-transi Cause (Ulsease or injury the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death filled in by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy performe 2 🗌 No 1 ☐ Yes 2 ☑ No 1 🗌 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X other patient hospice 2 No ဂ္ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funerel D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier nsRujapalnemo 29d. Date signed (Month, Day, Year) D0057465 8/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bathmore MD Z1209. 5203 2835 Smith AV NSRAJAPAKSE MO 31. Date filed (Month, Day, Year)

State

Registrar DHMH 17 Rev 06-2011

**ORIGINAL** 

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ A LIGHST EROY UCDOWELL 7 20/2 10:457 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future Care Baltimore N/A Social Security Number If Under Year If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 250-42-9765 Months Hours Director 1 🛛 M 2 🗆 F Yrs 08/07/1927 85 S. Carolina Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits rector MD Baltimore Co. Reisterstown 1 Yes 2X No ö 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a oı Examiner must be Funeral 12020 Reisterstown Rd. 21136 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan any injury or other traumatic event, the Medical Exan If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 9th Grade College (1-4 or 5+) Custodian Lexington Market Should be filed with and Mental Hygier 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John McDowell Edna McGill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Taylor(niece) 5611 Bland Ave., Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State on-site Crematory 8-20-12 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Joseph MesBrown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD21217 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Shock, or head failure. List only one cause on each line nmediate Cause (Final Interval Between Onset and Death KENAL - Physician/ FAI /URE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consection of on Exami The law requires that the death certificate be executed sician and burial-trans resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown signed by t Part **U. Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, DEMENITA 1 Yes 2 No 3 Probably 4 Unknown schruic HEALT 24b. Were autopsy findings available prior to completion of cause of death? ASSOSF 24a. Was an autopsy has 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) R088852 DUGUST 20 ZOIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Solis Brung MANGIAND 21802 KNTHUSSN C. DIAMOND 7.0. SUX ZG/3 31. Date filed (Month, Day Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 27063 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 22, 2012 Physician/ Ernest Balloqui Molineiro 7:59A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7816 Renshaw Road Pasadena Anne Arundel If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** N Y Days Hours March Day Year) 932 279-32-6431 80 1 🖺 M 2 🗆 F Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland the Madical Examiner must be notified at Director Maryland Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 239 7816 Renshaw Road 21122 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "natural", or δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 end 2 should be filed within 7. Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than ' any injury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4 or 5+) Welder Industiral Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Obdlia Molineiro Helen Balloqui 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernie Molineiro 7816 Renshaw Road Pasadena MD 21122 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Md Veterans Cemetery: 8/24/2012 Crownsville MD 21. Signature of Funeral Se 22. Name and Address of Facility Stallings Funeral Home P.A. Road Pasadena MD Mount used the death. Do not enter the mode of dying, such as cardiac or respiratory 23a. Part 1. Enter the dise se, or complica Approximate Interval Between ist only one ca shock, or heart failure Onset and Death Immediate Cause (Final Physician/ e disease or condition resulting in death) Medical is a**g**onsequence of) Due to (or Examiner Esquentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sate hes been signed by the attending physician and page 2 should be detached for use as the burlal-transit To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day, Year) 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation М 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signaty and title of certifier 29c. License number 2012 who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 06-2011

2 4 20

32. Registrar's Signature

6

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10c, perFH, G930, 8/24/2012, WS
State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death Reg. No. 2 2. Date of Death Physician/ 2012 Angus?  $\varphi^{\cdot}$ Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death tospice RandallStowx 6. Sex If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Months Hours Min Country Director 1 M 2 F 65 Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-f sho any injury or other treumatic event, the Marical Examiner must be notified at any injury or other treumatic event, the Marical Examiner must be notified at any injury or other treumatic event, the Marical Examiner must be notified at any once. 10c. City, Town or Location Catonsville 10a, State 10b. County 10d. Inside City Limits **Funeral Director** 1 Yes 2 No adonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Middl 2122 ISA 12. Was Decedent Ever in U.S. Armed Porces?

1 ☑ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 🗌 Widowed 4 🗌 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) C theham OV Ker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဥ 1100 rie Mandows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, U, adde tood KO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility owc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death END Stage Peripheral Vascular Disease Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) \_\_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N After this certificate 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: မှ 1 Tes 2 1No 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely To the I within 2 To the F only one) 29b. Signature and title of certifier 29c. License number NSRajapalareME 29d. Date signed (Month, Day, Year) 00057465 23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 5703 21209 N Sky apakse MD Smith Baltimore 2835 32. Repistrar's sport State Registrar

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ledical Examin	er			anley		b. City, Town, or	Location of I			. County of Dea	ath
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AD 2 shorth and 27 is umatin		Ronda Taylor	-Mother	Too. 1	3411	Vargus sition (Name of o	G1rc1	e Apt.#2	200	Location - City	y or Town, State
re, rand Thealt Thealt		20a. Method of Disposition  1 X Burial 2 Cremati	on 3 Removal f		rematory or ot	her place)	omotory,		R	andalls	town, MD
Baltimore, permit. Pages 1 ar Department of Het Important: If ite injury or other tr	- 1	4 Donation 5 Other	Specify:	K:	ing Mem	l. Falk	ss of Facility	Wylie F	iner	a Home	P.A.
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Cospita fospita t hours functa	2						e, date and p	lace, and due to th	e cause(s	and manner a	es stated.
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		30. Name and address of per Patricia Aronica-P		istant Medica	l Examiner	900 W. Ba	altimore S	treet, Baltimo	e, MD	21223	
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		Funeral Director		5. Social Security Number 214-12-0071 6. Sex 1 Graph 1 Graph 2 Telephone 1 Graph 2 Telephone 2 Telepho	8. Date of Birth (Month, Day, Jan. 12,	Year) 9. 8 1922 1	Birthplace (State or Foreign Country) Vew York
3		yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
18		Ba-fst	ctor	Maryland Baltimore Towson			1 Tyes 2 No
1055		ath with th	Funeral Director	10e. Street and Number 800 Southerly Road 10f. Zip Code 21286		0g. Citizen of What USA	
at.	215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. item 27 is marked other than "naturel; or Items 23a or 28a-1 show other treumatic event, the Model Examination to Incit	by	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates:		Black, W	merican Indian, hite, etc. Vhite
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August	Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		comptant cromatons or other place)		20c.Location - City Baltimore	
au	Balt	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Leonard J. Ruck, In 5305 Harford Road	nc. Baltimo	ore MD 2	1214
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W	Vital	ysicien: The l is certificate ha director, page	Be	25. Was case referred to predical examiner?  1 Types 2			
	of	Phys or this oral dii	. To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Tursing Ho		ence 6 Other (5 ow injury occurred	Specify)
	ion	utending Phy death, ctor: After thi y the funeral	atior	1 atural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		,	
	Division	tal or Atte s after de al Directo ed in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  2 ie. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town		r Rural Route Number,
		To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certificacompletely filled in by the funeral director.	edicai	29a. Certifier (Check ont one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check ont one)  Nedicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	red at the time, d	ate and place, and	due to the cause(s)
•	•	To t	M	29b. Signature and title of certified  Dhist can  29c. License number  297	69 2	9d. Date signed (M	onth, Day Year)
3				30. Name and address of person who completed cause of death (Item & 3a) (Type, Print)  Why William 5 (6 W · Ru	lling	d Bn	hand
./		Sta Registi		31. Date filed (Month, Day, Year) 7 32. Registrar's Signature AUG 2 4 2012 Sebus S. January	J		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Donald M. O'Dell 26 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice of Queen Annes Inc Centreville Queen Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min Hours Director 86 222-14-7281 1 🛣 M 2 🗆 F Pennsylvania June 15, 1926 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Tes 2 No Millington MD Kent 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21651 Box 436 items death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 1946 - Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc 0 by 1 Never Married 2 Married altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: "natural" Completed 3 X Widowed 4 Divorced 1948 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) petroleum service technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Julnar Helene Oberg Ray Dorn O'Dell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
783 Rolling View Dr; Annapolis, MD 21409 19a. Informant's Name/Relationship (Type, Print) Susan Brandon - daughter of Health a other 20a. Method of Disposition 20b. Place of Disposition (Name of cof F Date 20c. Location - City or Town, State Department of Important: If i any injury or o 1 🗆 Burial 2 🗀 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CHRONIC HEART DISEASE ISCHEMIC Ph\_sician/ years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence oi). use as the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached t g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed Yes 2 2 No 1 Yes 25. Was case referred to medica filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 ☐ Yes 2 🗶 No Hospice 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Helen A Noble MD 122 Speer Rd. Chestertown, MD 21620 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certification

29c. License number

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Ma Registrar	ryland / Depa <i>Cer</i>	artment of F tificate of D			001	2 27068	
ī	Physicia	n/	1. Decedent's Name (First, Middle, Last)  Alma Gaye		2. Date of Death					
	Medic Examin	al	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea				Aug	b b bward		
	Funeral Director		110000	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		thplace (State or Foreign untry) <b>VA</b>	
	ryland -f show ied at	ctor	Usual Residence of Decedent  10a. State 10b. County  MD Howard	10c. City, Town or Loc	ation	Highland			10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
	ith the Ma 23a or 28a st be notifi	Funeral Director	10e. Street and Number 13009 Highland Road		10f. Zip Code	20777	10	g. Citizen of What Co	ountry?	
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Eye Armed Forces? 1 Yes, 2 N If Yes, Give Year or Dates.	o If	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Spenic Origin? (Spenic Origin); Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:		
21215-0036	ithin 72 hou ene. r than "nat the Medica	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give k	ent's Usual Occup: ind of work done o NOT use retired) <b>Hom</b>	turing most of work	ing 16	6b. Kind of Business <b>Own</b> I		
land 2	l be filed w lental Hygi rked other tic event, t	To Be	17. Father's Name (First, Middle, Last)  Cullen Quesenl	berry		18. Mother's Nam	e (First, Middle, Ma. <b>Mattie Fr</b> a	iden Surname) ances Simpki	ns	
, Maryland	id 2 should raith and M n 27 is ma er traumai		19a. Informant's Name/Relationship (Type, Print) Tim Sinclair Son-In-Law	19b. Mailin <b>1034</b>	g Address <i>(Street a</i> <b>6 Lombardi</b>	and Number or Rura <b>Drive Ellicot</b>	al Route Number, C. t City, MD 21	ity or Town, State, Zij	o Code)	
Baltimore,	Page 1 an ment of He cant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem <b>Atlantic C</b>	sition (Name of patory or other place Crematory, LL	Č Aug	Date 20 21, 2012	oc. Location - City or <b>Glen B</b> u	Town, State	
Balt	permit. Depart Import any inj	Ų.	21. Signature of Funeral Servicers			neral Home, P Columbia Pik				
aran.	Ph <sub>y</sub> sician/		23a. Part 1. Enter the deease, or complications that caused to shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	he death. Do not ente	r the mode of dying	g, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death	
Medical Examiner		er	sequentially list conditions,	consequence of):	Arte	allis	ease		Years	
S	ecuted and II-transit	dical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.	consequence of):						
09/	icate be executed physician and is the burial-transit	ledical	d							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Yes 2 ☐ Yes, outcome of 1 ☐ Live Birth 2 1 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 3 ☐ Yes, outcome of 1 ☐ Live Birth 2 ☐ Yes 3 ☐ Yes, outcome of 1 ☐ Yes Birth 2 ☐ Yes Grant at 1 ☐ Yes 2 ☐ Yes	Fetal death 3	Ectopic pregnand Other (specify)	Sy		23d. Date of de Month	23d. Date of delivery  Month Day Year	
ds, P.O.	quires that the second by the signed by the details and the details and the details are the second s	ted by Pl	Part II. Other significant conditions contributing to death but  Oavuar Heart Di	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba		the cause of death?	
Division of Vital Records,	The law recate has being page 2 sho	Completed by					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of	
ita	sician: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Othe	ace of Death (Checker:				
on of V	To the Hospital or Attending Physician: The k within 24 hours after death.  To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Certificate: To	27. Manner of Death 1		28c. Injury work	y at	28d. Describe how	ce 6 Other (Special Injury occurred		
Division	tal or Atte irs after de al Directo led in by th		3  ☐ Suicide 6  ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc.	/ - At home, farm, stre (Specify)	et, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
	To the Hospital within 24 hours To the Funeral completed filled	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner only one) 3 Certifying Nurse Practioner: To the bright Medical Examiner: On the basis of examiner.	mination and/or invest	igation, in my opinic	on, death occurred a	t the time, date and p	place, and due to the	cause(s) and manner stated.	
	To the within To the comp	-	29b. Signature and title of certifier	Mir	29c. License		7	I. Date signed (Monti		
	12		30 Name and address of person who completed cause of dea	ath (Item 23a) (Type, P	rint)	Rd Ma	ichsu	No Mr	21029	
	Sta Registra	te ar	31. Date filed (Nonth, Day, Year) 32. Registrar AUG 2 4 2012	s Signature						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Dorothy G. Pittman 08 2012 6:45p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor Care Nursing Home Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. (Month, Day, 1 M 2 X F **Director** 219-28-5798 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2730 Bryl Ave 21205 U.S.A. death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 2th grade (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event than Clerical Social Security Adm Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Haywood Pittman Partheria Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Brooks-Cousin P.O. Box 382, White Marsh, Md 21162 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Arbutus Memorial 8/4/2012Arbutus, March Hodgess of Facility t 4300 Wabash Ave, 21. Signature of F Baltimore, Md 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events sician and burial-tran Due to (or as a consequence of) resulting in death) Last ng physician a Physician/Medical Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months? Month Day Year 1 Yes 2 No signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ဂ္ဂ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner To the best of my knowledge ideath paramed at the time, date and place, and dust to the 29b. Signature and title oncertifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D72536 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUMIT BYUTANI 821 NEWTON ST Suite 308 Baltimore MD 31. Date filed (Month Pey, Year) 2012 3. Registrar's Signature State Darke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 08 2Day  $20\overset{\text{year}}{1}$ Ruby Porter 10:52a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4800 Yellowwood Ave Apt 418 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth O(5) 12 (12) 47 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Country) MS **Director** 65 587-12-2301 1 □ M 2X□ F Usual Residence of Decedent 10a. State 10b. County within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD NA 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21209 4800 Yellowwood Ave Apt 418 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. à Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Black 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Nurse Private Duty permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, : æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Benzi Bo Bo Rosia B. Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14239 Jib Street Apt 21, Laurel, Md 20707 Akim Oliver-Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Dona/tion 5 ☐ Other (Specify) 8/23/2012 On-Site Baltimore, Md 21. Signature of Funeral Service Licensee Name and Address of Facility

A F H West

Wabash Ave, Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Physician/Medical 2 70 Magny Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy after death.

Director: After this certificate Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 hour To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) halim. B D65616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shalini Boyapati, 2435 W. Belvedere Ave, Baltimore, Md 21215 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 24 DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 30 per DVR, G9 30, 87 247 2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Aug 17, 2012 Physician/ Joyce M Pescetto 10:54 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Paradise Assisted Living Catonsville **Baltimore** 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** 213-26-9889 1 □ M 2 🔀 F Months Days Hours Min. (Month, Day, Year) Jul 2, 1931 81 **Tennes** Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Examiner must be notified at any injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director **Baltimore** Catonsville 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2135 Rockwell Ave 21228 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 Wallace Long Vivian Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veda Smith Daughter 2135 Rockwell Ave Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Crest Lawn Memorial Gardens 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 23, 2012 Marriottsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 whenled as Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nmediate Cause (Final Onset and Death Physician/ isease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to in recipitate cause. Enter Underlying Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Certificate: To 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventioning in a process Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number MUG 8-20-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8028 Ritchie Highway Pasadena, MD 21122 Dodge Karin 31. Date filed (Month, Day, Year) State AUG 2 4 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month harles m. Rock 3:41PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Manyland Medical Center Baltimore Citz n/a University Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 218-03-1673 **Director** 1 X M 2 . F Oct 6, 1917 Maryland Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits by Funeral Director MD. **Baltimore** Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Beehive Place Apt D 21030 USA 11 Marital Status 12. Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Developer & Builder Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Charles Rock, Sr. Esther Garner 19a. Informant's Name/Relationship (Type, Print) item 27 Thomas L. Rock/ Son 1410 Bonnett Place #E Bel Air, MD. 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Hillton Service Co. 8-23-12 Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name angloders fowson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Juneral ervice Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Stenosis Acrtic 210 views Medical resulting in death) Examiner 1 Embolism ä wieks Sequentially list conditions, if any, reading to increasing cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical no the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate becompletely filled in North IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 0 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 1497021455 d cause of death (Item 23a) (Type, Print) Chinwa NWCSLL, M.D. 30. Name and address of person who comp 5 Greene St Baltimore, mD 21201

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

2 4 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:50 P M August 17, 2012 William Rothert Frederick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manchester Carroll Longveiw Nursing Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours t**√** M 2□ F 97 Yrs. 8, 1914 Nov. Indiana Director 311-09-8931 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show ed other than "natural", or items 23a or 28a-f show event, the Medical Examination by Inciting the modified of 1 ☐ Yes 2 ☐ No Director Carrol1 Manchester 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21102 United States 3068 Crown Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after Yes 2 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify. à 3 Widowed 4 Divorced Year or Dates: W.W. II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Representative <u>Pharmaceuticals</u> marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi Smith Henry Rothert Amelia Katherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s' if Health a 3068 Crown Circle, Manchester, MD Judith J. Eckenrode / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20a Method of Disposition permit. Pages Department of Important: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Uniformed Sers. Univ. 08/21/12 Bethesda, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services 21. Signature of Funeral Service Licensee 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** raus resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) Box 68760 attending physician certificate be Physician/Medical the, as IF FEMALE: esn ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy for Month Day Year 5 Other (specify) ☐Yes 2☐No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe cate has I page 2 s certificate 1 ∐Yes 2 PNo 1 ☐Yes 2 ☐ No Hospital or Attending Physician; 24 hours after death. Funeral Director; After this certifice director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Application 

Nursing Home 

5 Residence 

6 Other (Specify) 1 ☐ Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who comp

7613

ted cause of death (Item 23a) (Type, Print)

po

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ISEPHINE 2012 August 9:00A Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Baltimore 3305 Woodring Avenue 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 2, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 - M 2 X F Director Yrs 215-28-5784 83 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore County 1 Yes 2xXNo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 3305 Woodring Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. Completed Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bank of Baltimore 12 yrs. N/A IRA Clerk permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marie E. Staffa Joseph Gladsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 Woodring Avenue Baltimore, Md. 21234 Carroll T. Smyth (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 8-27-12 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 22. Name and Address of Facility re of Funeral Service Acensee Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland Hou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially liet conditioner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran. Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has I director, page 2 : autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 🕱 No 1 Yes ည 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at After 1 Natural injury 5 Pending work ithin 24 hours after death.

the Funeral Director: At ompleted filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 within 2 To the F only one) 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print)

RROLL, M.D. 110 PHILADELPHIA RD, #108 30. Name and address of p MARYE OH RROLL, MO

State

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 27075

		1- For State Registrar	Certific	cate of Dea	ath		Z U 1 2 g. No.	2101		
Physici Medical Exami		1. Decedent's Name (First, Middle, Last	Kenneth I	Darryl St	torey	2. Date of Death Month August 18,		3. Time of Death 2138 hrs		
		4a. Facility Name (if not institution, give Sinai Hospital	street and number)		r, Town, or Location of Deat timore	h	4c. County of Death			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs, 8. Date of Birth (MM/DD/YYYY) 9. Months Days Hours Min. April 16, 1955								
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits		
land f show	į	MD	Ba	Itimor				1 Ves 2 No		
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral Director	2424 Bibury	Lu Unit 1	02	21244		g. Citizen of What Count			
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heath and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she re other traumatic event, the Medical Examiner must be notified at once		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No 1Yes, Give Year	If Yes, spe	dent of Hispanic Origin? ( Society Cuban, Mexican, Puerto		14. Race - Americ White, etc. Specify:	an Indian, Black,		
D 21215-0036 should be filed within 72 hours after and Mental Hygene. is marked other than "natural?, afte event, the Medical Examiner	eted by	15. Decedent's Education (Specify onl Elementary/Secondary (0-12)	or Dates: / highest grade completed) 16a  College (1-4 or 5+)	a. Decedent's Usu	al Occupation (Give kind of vorking life. DO NOT use ref		16b. Kind of Business/In	dustry		
5-0036 led within 7 Hygiene. other that	Completed	12	Ce	ertified		Operator	UPS			
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Last)	orev		Elest		/			
MD 21 d 2 should th and Me n 27 is ma umatic cv	유	19a. Informant's Name/Relationship (Ty Randaly) F	be, Print) 1 Storey 1	9b. Mailing Addre	ss (Street and Number or	Rural Route Num				
re, M 1 and 2 F Health f item 2	1	20a Method of Disposition  1 Burlal 2 Cremation 3	20b. Place	e of Disposition (N atory or other place	ame of cemetery,	Date /	20c. Location - City or T			
		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licens	Loui	don R	and Address of Facility	25/2012	Baitimo	re, MI)		
	2	Crueit Ser	my fr	4600	Liberty H	eights/		nre, Mi)		
Physician /Medical		23a. Part I. Enter the disease, or compli- failure. List only one cause on each		not enter the mode	e of dying, such as ĉardiac (	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death		
Examiner			ue to (or as a consequence of):							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence of):							
at d	Medical Examiner	(Disease or injury that initiated C-	ue to (or as a consequence of):							
o, e be executed ysician and burial - transit	ical	d. UNPENDED	AMENDED #1, per me,	g931 9-1	4-12 sm					
760, icate be ex physician the burial		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnance	_	- [ ]		23d. Date of delivery			
Box 687: death certific	Physician/	past 12 months?	1 Live birth 4 Pregnant at time of death	Fetal deat  Other (Sp.		ancy	Month Da	y Year		
that the des		Part II. Other significant conditions	Unknown Contributing to death but not resulti	ng in the underlyi	ng cause given in Part I.	23e. Did tob	acco use contribute to the	e cause of death?		
s, P.O. nires that the signed by d be detack	ed by	<u></u>					2 ✓ No 3 Proba			
cords, law requir has been s	Completed					24a. Was ar autops perform	y prior to co	ppsy findings available mpletion of cause of		
II Re		25. Was case referred to medical			26.Place of Death (Check	1 ✓ Yes 2 only one)	No 1 ✓ Yes	2 No		
f Vitz Physicia r this ce	To Be	1 🗸 Yes 2 No	spital: 1 Inpatient 2 ER/0			ng Home 5 R				
ision of Vital Rec Attending Physician: The r death. ector: After this certificate by the funeral director, page		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	Aug 18, 2012 210	. Time of Injury 00 hrs	28c. Injury at Work? 1 Yes 2 ✓ No		ow injury occurred corcycle involved in	collision		
Division of Vital Records, ital or Attending Physician: The law require ans after death.  ral Director: After this certificate has been silled in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be determined	28e Place of Injury - At home	farm, street, facto	ry, office building, etc.	or Town, Sta	reet and Number or Rura ate) berty Heights Avenue			
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day)									
F S	Me	29b. Signature and title of certifier	ind manner stated.	2	9c. License number		29d. Date signed (Mont	h, Day,Year)		
	-	30. Name and address of person who on	O.C.M.E. August 19, 2012  Name and address of person who completed cause of death (Item 23a)							
- \		Donna M. Vincenti, MD A	ssistant Medical Examine		altimore Street, Baltir	nore, MD 212	23			
St Regist		31. Date filed (Month, Day, Year) AUG 2 4 2012	32. Registrar's Signature	1						

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 27078												
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Deat</li></ol>	3. Time of I	Death								
	Medic Examin	al	Carol Margaret Smith  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. Count									ar <sub>2</sub> 9:57 PM			
	EXAMILIE .	eı	Future Care - Northpoint		4b. City, lowii,	or Location	OI Deali			timor					
	Funeral Director		5. Social Security Number 072–38–0829   6. Sex 1 ☐ M 2 🔀 F	ge (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Day			8. Date of Birth (Month, Day,			olace (State or try. York	Foreign			
			Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo						1	0.1 1	11			
larylan	a-f sh iffied a	ecto	MD Baltimore	Toc. City, Town or Le	cation						0d. Inside City 1  Yes				
h the M	3a or 28 be not	Funeral Director	10e. Street and Number 1046 Old Northpoint Rd.		10f. Zip Code 212	24		1	10g. Citizen of USA	What Cour	try?				
eath wi	ems 2 er musi	uner	11. Marital Status 12. Was Deceden	Ever in U.S. 13.	Was Decedent of	Hispanic Or	rigin? (Speci	ify Yes or No-		ce - Americ					
after de	l", or it kamine	þ	1 ☐ Never Married 2 ☐ Married	No 19/0-	If Yes, specify Cu			can, etc.)		ack, White,	etc.				
hours after	natura fical E	letec	Year or Dates.	1974 16a. Dece	dent's Usual Occ	upation		- 1	16b. Kind of I		dustry unik				
within 72	than " the Med	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 o	5+) life. D	kind of work don 10 NOT use retire cretaria	d)	st of working	7			•				
filed wi	I Other vent, tl	Be	17. Father's Name (First, Middle, Last)	56	CICCALIO	_	ner's Name (	First, Middle, N	Maiden Surnan	ne)					
uld be filed	i Menta narked natic e	욘	William Pedersen Mary Stephen												
d 2 sho	Department of Health and Mental Hyglene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Barbara Holland - frie	d 19b. Maili	ng Address (Stree 15 White	et and Numb way;	er or Rural I Bal <b>ti</b> r	Route Number, nore, M	City or Town, D 2121	State, Zip (	Code)				
ge 1 an	nt of He : <b>If</b> item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Star	20b. Place of Dispo cemetery, cre	osition (Name of matory or other p	lace)	Da	ite	20c. Location	- City or To	wn, State				
Dalullion	ortmer cortant injury	1	4 □ Donation 5 ☒ Other (Specify) in State  21. Sign turn Eunera Surgi Licensee  S. Wade. Dir	2	2. Name and Add	ress of Facili	<sub>ity</sub> Stat	e Anato	ту Воа	rd					
ğ å	Depar Impor any in	4	senni.	ector				St; Bal			21201				
			23a. Part 1 Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li Immediate Cause (Final		er the mode of d	ying, such as	s cardiac or	respiratory arre	est,		Approximate Interval Betw Onset and D	/een			
j N	/sician/ Medical		disease or condition	s a consequence of):						-					
Ex	aminer	e	Sequentially list conditions, b.	s a consequence of):						_					
nted	d ansit	amin	Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury that initiated events	Clobidia	Billiele	1.									
эе ехес	ician an Jurial-tr	dical Examiner	resulting in death) Last Due to (or a	s a consequence of):	DV.	,									
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th certifi	ttendin or use	ian/N		2 ☐ Fetal death 3						ate of delive	,	ear			
. DOX	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	1 Yes 2 No 4 Pregnant 9 Unknown		Other (specify)					Ontri	Day re	rar			
es that	igned b	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
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The law	ate has page 2	Completed	Sint ble sercions					autops perform 1 \(\supers \) Yes	med?		mpletion of ca				
VILCIAN:	certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No		10	Place of Dea									
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tendin	tor: Aff	Certificate:	2 Accident Investigation		M 1	Yes 2									
al or Attendir	s alter		4 Homicide determined building, e	njury - At home, farm, sti etc. <i>(Specify)</i>	eet, factory, offic	е	28	3f. Location (St. City or Town		ber or Rural	Route Numbe	er,			
Hospit	within 24 nouts after dearth.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of Continuous 2 Continuous Problems 1 Text	examination and/or inves	stigation, in my opi	inion, death o	occurred at the	ne time, date an	d place, and d	ue to the car	use(s) and man	ner stated.			
To the	within <b>To the</b> сопр	Σ	only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier	e best of my knowledge,		nse number	e and place,		9d. Date sign						
			0.4.	<u> </u>		57381	41	[ [	3/20/2	212					
-			30. Name and address of person who completed cause of Shushil Sagar Mo - 8813 W	death (Item 23a) (Type,	Print)	204.0	h. K at . 11	. UN							
	Stat	.e	31. Date filed (Month, Day, Year) 62. Regis	rar's Signature	Kel	1 - 1	- V-1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	u / ( ) _							
4	Registra	ır	AUG 2 4 2012 Census	- 1- 17											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty Lois Medical Speck August 9:30 PM 18 2012 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5123 Westridge Rd. Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Months Hours Min **Director** 321-16-1937 1 ☐ M 2**X** F 93 Yrs 09/03/1918 New York Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5123 Westridge Rd. 20816 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 Divorced Completed er than "natur , the Medical ! 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the r traumatic event, the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elis Ahlquist Lily t. Page 1 and 2 should be thrent of Health and Mentant. If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Mary Speck / Daughter 5123 Wes<u>tridge Rd., Bethesda, MD</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 08/27/2012 Beltsville, MD Signature of Funeral Service Licensee M00382 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) ALZHEIMER'S DISEASE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): the burialsigned by the attending physiclan d be detached for use as the استنما Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2XXNo Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available has autopsy performed? 1 Yes 2 No. prior to completion of cause of death? After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Tyes 2 No 2 Accident
3 Suicide Investigation 6 Could not be after death filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a Medical 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) D37142 AUGUST 21, 2012 person who completed cause of death (Hern 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 06-2011

State Registrar GEOFFREY COLEMAN M.D.,

32. Registrar's Signature

1355 PICCARD DR., ROCKVILLE, MD

20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 5 per fh g930 8-29-12 vt
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Michael Eugene Szymanski 2012 Aug. 17 7:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1636 Bedford Rd. Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, YOCt. 5, **Funeral** Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 🗆 F Days Hours 61 Oct. Maryland **Director** 1950 Yrs. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie Maryland | Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1636 Bedford Rd. 21061 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Upholsterer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Maxamillion Szymanski Myrtle Ruth Bark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1636 Bedford Rd., Glen Burnie, Maryland 21061 Salina Szymanski / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 😾 Cremation 3 🗆 Removal from State August 2012 Atlantic Crematory 4 🔲 onation 5 Other (Specify) Glen Burnie, Maryland of Puls ral Service Licensee 21. Signati Kirkley-Ruddick Funeral Home, P.A. 0/1 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 10 Months Ph\_sician/ disease or condition resulting in death) Small Cell Lung Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury led by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death Unknown g 🗌 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes 2 No Yes 2 No ospital or Attending Physician: hours after death. 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No Other: ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? \_\_\_1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred Director: After 5  $\square$  Pending injury 1 X Natural Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. o the Ho... within 24 hr To the F Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certifier 29c. License number August 17, 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) g. 21061 AUG 2 4 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#29d, perpHYS, G930, 8/24/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KOFI Month / Kodie 4:51PM 2012 Medical 4a. Faqility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Columbia Howard (scheral Countr HOSP: ta 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) Director none 0 MD 1 🗹 M 2 🗆 F Yrs 08/10/2012 Usual Reside 28a-f show 10a. State 10b. County 10c. City, Town or Location the Maryland treumetic event, the Medical Examiner must be notified at Director 10d. Inside City Limits **Baltimore** MD Randallstown 1 ☐ Yes 2 🗹 No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? by Funeral filed within 72 hours after death with 3928 Chaffey Rd. 21133 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☑ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☑ Never Married 2 ☐ Married "naturel", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: **Black** Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working end Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 end 2 should be Eric Antwi Danielle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3928 Chaffey Rd. Randallstown, MD 21133 Danielle Allen mother 27 other item 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e
Depertment of H
Importent: If ite
eny injury or ot
once. Date 20c. Location - City or Town, State 1 Burial 2 Dremation 3 Removal from State Atlantic Crematory, LLC Aug 16, 2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Se 23a. Part Enter the dis sec, or complications that a used shock, a heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ xtreme rematurit disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physicien end for use es the burlal-trensit or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 No certificete has been signed by the lirector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 2 🗌 No 1 🗌 Yes the funerel director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital of thin 24 hours af the Funerel D Medical within 24 hound to the fune of the function of the fun 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 1,2 29b. Signature a 46242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Columbia 100 PKWy 31. Date filed (Month, Day, Year) AUG 2 4 2012 32. Registra State Registrar

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2307 Medical Examiner 4a. Facility Name (if not institution, give street and number) County of Death mam 2/timore limahos otting 5. Social Security Number Age (In yrs. last birthday, f Under 1 If Under 24 Hrs. 8. Date of Birth **Funeral** Months Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Nottingham 1 Yes 2XXNo 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3714 Timahoe Circle 21236 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 X Never Married 2 Married Completed by ☐ Yes 2 🛛 No hours after Specify. White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Stephen Shock Stephanie Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Shock- Father 3714 Timahoe Circle Nottingham, MD 21236 tem 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St Joseph Cem 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/20/2012 Nottingham, MD 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Rd. Nottingham, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart unure. List only one cause on each line. Approximate Interval Between Onset and Death

HR 40 M Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin Cause (Disease or iinjury that initiated events resulting in death) Last g physician and strans Due to (or as a consequence of): Physician/Medical nding IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? performed? 1 ☐ Yes 2 XNo Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) 횬 1 \sum Yes 4 ☐ Nursing Home 5 ▼ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Funeral Director: After completed filled in by the funer Hospital or Attending Natural 5 Pending injury hours after death. 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

State Registrar

2

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

**Division of Vital** 

o completed cause of death (Item 23a) (Type, Print)

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 2012 Mary W. Surasky 3:46 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Director 578-48-7054 1 □ M 2 🗓 F Dec. 13, 1917 Maryland or than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Timonium 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2525 Pot Spring Road #K305 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Specify: white Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Pege 1 end 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the M-sho once. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Ay(与UST Z0 Baltimore, Maryland 212 College (1-4 or 5+) Owner 0 Staffing Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur McColgan Frances Catanzaro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5624 Williams Road; Hydes, MD 21082 Christine Rusk niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/24/2012 Towson, MD 21. Signature of Fun ral & rvive Lice 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use es the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate has 2 No 1 Yes filled in by the funeral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 5 Pending Natural Work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier within 24 hou To the Funel completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 22° 2012° 12:51a м Stapf M Loretta Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice Columbia (Columbia) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 9, 1924 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 213-20-6990 Pennsylvania **Director** 1 □ M 2 🗓 F Usual Residence of Decedent 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3210 Lorena Ave. 21227 USA filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, æ 18. Mother's Name (First, Middle, Maiden Surname) Mary Necker 17. Father's Name (First, Middle, Last) and Mental Fisher is marked or ည Sullivan Edward Page 1 and 2 should be Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is Milton Stapf (Husband) 3210 Lrena Ave., Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ō 1 X Burial 2 Cremation 3 Removal from State Moreland Memorial Cem. 8/25/12 artment ortant: I injury o Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. P Der artm Importa any inju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1—Timer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fnysician/ PSEUDOBULBAR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RESFIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 124 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Day Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DYSPHAG: A SEVERE 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bigwedge$  Other (Specify) 1 Yes 2 No ျု 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA MER 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 4BBAS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABRAS MD OLUMBIA 6336 CEDAR 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

AUG 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20a-c Per ANA BD G930 8/24/2012 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ william Year 1015 PM Medical 2012 AU GUST 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Ellicott City Health & Rehab Howard Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Director** 579-58-6030 Hours (Month, Day, Year) 67 1X M 2 - F Usual Residence of Decedent 1944 Dec 15. Washington, DC 28a-f show 10a. State must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Howard Fulton 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12026 Scaggsville Rd. 20759 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?

1 Yes 2 No ō þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Black, White, etc. "natural", If Yes Give 1 Yes 2 X No Specify 3 Widowed 4 Divorced White Completed Specify Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) unk unk stock worker Giant Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Townsend permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Margaret Elizabeth Townsend other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Maijing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code, 1452 Harvard Cir #2; Melbourne, FL 32905 Emma Holbe - sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemeBostotry University School of Medicine Date 20c. Location - City or Town, State 8/23/2012 Boston, Massachusetts Signature Runeral Service Libensee Ronald Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final A Physician olomo arcinomo Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Advanced Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burlal-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Pregnant at time of death Month signed by the aid be detached if Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? been sig should b Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? this certificate has ral director, page 2 24a. Was an autopsy 2 No Yes 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 은 Hospital: Other 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending injury work? the Accident Investigation M 1 🗌 Yes 24 hours after deatle Funeral Director: 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3064

Registrar

DHMH 17 Rev 06-2011

State

30 Name and address of person who complete Ramcsh Sababalini

24

31. Date filed (Month, Day, Year)

last 2/20

pleted cause of death (Item 23a) (Type, Print)

11 201-109 Back

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20 Day Ethel Thomas 2012 Cecelia 1:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1666 Shannon O Circle Severn . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗆 M 2 🗓 F Days Hours Min 72 3-15-1940 Director 212-44-6912 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severn 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1666 Shannon O Circle USA 21144 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 X No Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Factory Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Oscar Crump Helen Gertrude Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Lloyd L. Thomas/spouse 1666 Shannon O Circle Severn MD 21144 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other Metro Crematory 1 Burial 2 X Cremation 3 Removal from State 8/22/2012 Catonsville MD 4 Donation 5 Other (Specify) 21. Signatu of Fundal Service 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy S Glen Burnie MD 21061 22. Name and Address of Facility M01364 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phusician/ ouning due in Mary disease or condition years Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 2 No been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has e 2 autopsy death? perform 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ဂ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending ieral Director; A 1 Yes ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basi of my included death occurred at the fine, date and place, and due to the cause(s) and manner stated (Check within 2 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mirza M. Nusairee, M.D. 1401 Madison Park Drive, Glen Burnie, MD 21061

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar 27085 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 23, 2012 Year Physician/ David Ross Taylor 1:12 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Oak Crest Care Center Parkville Parkville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 213-26-9339 Director 1 X M 2 - F Maryland 5/2/1930 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 Yes 2 No Marvland 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21234 8800 Walther Blvd "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Completed by 1 Never Married 2 X Married 1XXYes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea Elementary/Secondary (0-12) College (1-4 or 5+) Mass Transit Admin. <u>Purchasing Manager</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Hatch Adam Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8820 Walther Blvd Apt 1410 Parkville, MD 21234 Betty K. Taylor / wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Parkwood Cemetery 8/27/2012 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Signature of Juneral Service Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Medical END STAGE demenliA disease or condition resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No ŏ Month Day Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASCVD1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \sum \) Yes \( 2 \sum \) No 24a. Was an page 2 autopsy performed director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 Vo မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29d. Date signed (Month, Day, Year A067343 Ther BIH. PARKVILLO, MJ. 21234 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ August 22, 2012 Year 10:10 PM Fred Smith Whisenhunt, Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice - Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 246-44-0300 **Director** 1 X M 2 D F 78 1934 North Carolina Jan. 25, Usual Residence of Decedent or 28e-f shov 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or Items 23e or 28e-f shor traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 Tyes 2 X No Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11629 Falls Road 20854 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 1 to Yes 2 □ No If Yes, Give Year or Dates 1957 – 59 1 Never Married 2 Married 호 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Chemical Engineering Patent Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Fred Smith Whisenhunt Margaret Poovey 1 and 2 should b of Health and Mer item 27 Is mark other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark R. Whisenhunt (Son) 13309 Beall Creek Court, Potomac, Maryland 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1 a
Department of H
Important: If ite
eny injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/23/2012 Catonsville, Maryland 21. Signature of Funeral Service LicenseeAlyson Taylor 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Prostate Cancer resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. burial-tran and resulting in death) Last Due to (or as a consequence of): ettending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the e 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si ral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 12 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) HOSpice 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) R143201 23.12 50

Registrar DHMH 17 Rev 06-2011

State

6001 Muncaster Mill Road, Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

Debrah Miller,

31. Date filed (Month, Day, Year) AUG 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Walter 0321 AM Parris White Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Director** 113-58-9646 1 XM 2 🗆 F 51 Yrs Oct. 7,1960 New York 28a-f shov 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 Yes 2X No Maryland Joppa 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 21085 United States 418 Macintosh Circle 12. Was Decedent Ever in U.S Armed Forces? 19 1 X Yes 2 No If Yes, Give 100 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, orces? 2 □ No 1978-Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify. Black 1994 3 - Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Wire
life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+ Communications the Construction Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Walter Vernon White Gladys Ruth Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code S Important; If item 27 is any injury or other trauonce. Jeannine C. White-Moody/Sister 418 Macintosh Circle, Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 08/23/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a c sequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical as IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, been si should Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 No patient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗌 No 24 hours after death. Funeral Director: After 28d. Describe how injury occurred 1 Alatural 5 Pending injury the Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nursis Fractilitioner: To the best of my knowledge, ceals occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ho completed cause of death (Item 23a) (Type, Print) LPARC 32. Regis r's Signatur State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death D17A Physician/ 2 Day ELWOOD 2012 WOLF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8111 Bird Lane Windsor Green Prince Georges Greenbelt 5. Social Security Number 8. Date of Birth (Month, Pay, Year) Sept. 18, 1921 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In yrs. last birthday) Days Hours Washington DC 577-28-6175 Director 1 XM 2 □ F 90 ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.

If Ifem 27.5 marked other then "natural", or Items 23e or 28e-f show or other treamatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince Georges 1 🗆 Yes 2 👽 No Greenbelt 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8111 Bird Lane Windsor Green 20770 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1942— 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1943 Black, White, etc. 1 Never Married 2 Married 1 XYes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Army Corps of Elementary/Secondary (0-12) College (1-4 or 5+) Ships's Officer Engineers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George E. Wolf <u>Marv Eva Laughlin</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If Item 27 is eny injury or other treu Claire wolf/white Bird Lane Windsor Green GreenBelt, MD. 20770 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory, Inc. 08/23/2012 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityCremation Society of Maryland, Inc reof Fuscial Service Licensee Stephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or conditi resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inureal director, page 2 should be detached for use as the burlar-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 Yes Yes Division of Vital 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 \( \subseteq \text{ Nursing Home } 5 \( \frac{1}{2} \text{ Residence } 6 \subseteq \text{ Other (Specify)} \) 1 ☐ Yes 2 Po No မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 06-2011

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

BUB

Date filed (Month, Day, Year,

AUG 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23PII Per PHY G930 8/24/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, pr Location of Death **Examiner** 4c. County of Death D If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) UNK Months Days Hours Min. Director 219-56-4269 1 M 2 D F 60 Yrs Usual Residence of Decede farch 16, or than "netural", or items 23e or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Baltimore 1 Kes 2 □ No MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21218 2538 Asquith St. within 72 hours after death with 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?unk Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Un 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hyglene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) unk unk Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ Pe permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 is marke ery Injury or other traumatic once. unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah George - sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖺 Other (Specify) In State cemetery, crematory or other place) 24 Souther of Financial Service License Ronal Service License Wille 22. Name and Address of Facility State Anatomy Board nyector 655 W. Baltimore St. Baltimore, MD 21201 Part Nenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Dectopic pregnancy in the past 12 months?

1 Yes 2 No ō Day 5 Other (specify) signed by the at Id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Human Immunodeficiency Virus Division of Vital Records, cate has been sig Completed 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔽 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) and title of certific 29b. Signatur¢ License number 29d. Date signed (Month, Day, Year) 30. Name and address on who completed cause of death (Item 23a) (Type, Print) of pe 21287 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 27090 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Calvin 07:55 A<sup>M</sup> Warner Medical August 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7964 Elizabeth Road Pasadena Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-68-7856 Months Davs Hours Min. May 27 <sup>rear)</sup>958 MD **Director** 1 X M 2 □ F 54 Yrs Usual Residence of Decedent 28a-f show er than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Pasadena 1 Yes 2 No Maryland Anne Arundel ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours aftar daath with USA 21122 7964 Elizabeth Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married δ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should ba filad within 72 h end Mental Hygiena. Elementary/Secondary (0-12) College (1-4 or 5+) Service Director Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Parker Delores Ε. John Warner Sr. C. 1 and 2 should be financed to the Haalth end Meistern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7964 Elizabeth Road, Pasadena, MD 21122 Connie Warner (spouse) Injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of August 24 20c. Location - City or Town, State permit. Paga 1 g Department of h Important: If ite eny Injury or ot 1 Burial 2 Cermation 3 Removal from State Metro Crematory or other place! Baltimore, MAryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Ser 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or co-shock, or heart failure. List only ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death ancreatic admocorcinoma Immediate Cause (Final Physician/ tastanc disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of: ng physician and as the buriel-transit Exami Hospital or Attending Physician: The law raquires that the death cartificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attanding | IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 🖄 No 3 ☐ Probably 4 ☐ Unknown Completed been signal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has paga 2 autopsy performed? Yes 2 🖾 No this certificate 1 Yes 2 No diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🛭 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completaly filled in by the fun work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) redical 45148 august, 21, 2012 odiness of person who completed cause of death (Item 289) (Type, Print 0 050110 3708 Mountain Koud

State Registrar

cicarvo 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

osodena

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20°112 Williams August 5:55 A M Wayne Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Director 460-54-9241 1 X M 2 □ F 75 May 16, 1937 Texas er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20853 14202 Greenspan Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 😾 Married 1 V Yes 2 □ No If Yes, Give ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify. 3 Widowed 4 Divorced Completed Year or Dates. 1961-69 15, Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Civil Engineer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Williams Edna Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernestina F. Williams / Wife 14202 Greenspan Lane, permit. Pays.
Department of He.
Important: If item 27
any injury or other Rockville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 08/23/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral and Cremation Services M00382 Tallo 933 Gist 20910 Ave. Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ disease or condition PARALYSIS AGITANS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events for use as the burial-tran resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year detached 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ page 2 should be Records, 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate 2 🗌 No 1 🗌 Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) P Other: 4 Nursing Home 5 Residence 6 😾 Other (Specify) 1 ☐ Yes 2 ¬No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: A Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R143201 8.22.12

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day AUG 2 4 20 20855

DEBORAH MILLER, CRNP; 6001 MUNCASTER MILL RD., ROCKVILLE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Perenating 6930 Pealth and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 034 PM MHERINE NHEELER Physician/ 2512 Medical Name (if not institution, give street and number, Town, or Location of Death 4c. County of Death **Examiner** +OSPITKL BHTIMORE Year If Under 24 Hrs Date of Birth 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K F Months Country) 60 Director 218-58-9587 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland **Funeral Director** must be notified Baltimore tXX Yes 2 ☐ No MD NA 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 23a **USA** 21217 827 N. Arlington Avenue Apt.#506 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, "natural", or iter Armed Forces?

1 Yes 2XXNo Black, White, etcAfrican p 1 KNever Married 2 - Married Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: If Yes, Give Year or Dates Specify: American Completed 3 🗌 Widowed 4 🗌 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Factory Laborer 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce. မ Henry Alice Wheeler Isiah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3313 Croydon Road Baltimore, Maryland 21207 19a. Informant's Name/Relationship (Type, Print) Ronald Wheeler-Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08-15-12 Lansdowne, MD Zion Cem. Signature of Funeral Service Licenșee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DOXEMIA Physician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ₩No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 은 1 🗌 Yes ER/Outpatient 3 DOA Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 No within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu nvestigation Accident 2 Accident
3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Up The Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title Dause of death (Item 23a) (Type, Print)

7 AND W. Baltimere St, Baltimere MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 27093 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HOWARD S. WORTHINGTON, III AUGUS' 2012 4:07 A. Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 212-50-1718 1 X M 2 □ F 66 Yrs. MARYLAND 6/5/1946 Usual Residence of Decede or 28a-f show e notified at 10b. Count 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MD BALTIMORE TOWSON 23a o. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral must I 21286 IISA 1152 EAST GYPSY LANE or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, than "natural", or iter Armed Forces Black, White, etc. þ 1X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify:WHITE 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha the 12TH GRADE ARTIST RETAIL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be file f Health and Mental H item 27 is marked of HOWARD S. WORTHINGTON, JR. ANNA K. WAGNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT A. WORTHINGTON/BROTHER 2117 WOODFORK ROAD TIMONIUM, MD 21093 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) METRO CREMATORY, INC. 8/23/2012 CATONSVILLE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO217 8521 LOCH RAVEN BLVD. TOWOSN, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bladder Physician, months disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 2 No Yes 2 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) မ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) WIP LU filled in by the funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred thin 24 hours after death. the Hospital or Attending 1 Natural work? 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) within To the nd title of certifier 29d. Date signed (Month, Day, Year) 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARUES 670

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) AUG 2 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 321 ISABEL E. WILLIAMS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>UNION MEMORIAL HOSPITAL</u> CIT BALTIMORE Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs. Months Hours Min Director 217-56-8680 1 □ M 2 🕱 F 75 11/19/1936 TRINIDAD Usual Residence of Deced show 10a. State 10b. County 10c. City. Town or Location notified at 10d. Inside City Limits Director 28a-f MD N/A 1 X Yes 2 No BALTIMORE CITY 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral Page 1 and 2 should be filed within 72 hours after death with 719 MCKEWIN AVENUE 21218 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ NATHANIEL WILLIAMS ADVELIA SIMMONS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY B. WILLIAMS/SON 719 MCKEWIN AVE. BALTIMORE. MDor other 21218 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) DRUID RIDGE CEMETERY 8/28/2012 PIKESVILLE, MD Signature of Funeral Service Licensee MOO21 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. LOCH RAVEN BLVD. TOWSON. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician | disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE ase a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for t in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Pregnant at time of death Month Day Year signed by the a 9 Unknown g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 10 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate has autopsy funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural injury 5 Pending work? death. 2 No filled in by the Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one ditle of certifier 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year)

State Registrar AHIM

derson who completed cause of death (Item 23a) (Type, Print)

32. Regist ar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland	-	tificate of I	lealth and M Death		giene Reg. No.	2012	27095			
	Physici	an	1. Decedent's Name (First, Middle, Last)							ath Day	Year	3. Time of Death			
	/Medic		LILLIAN	A		AUGUS'		2012	06:00A M						
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or	r Location of Death			4c. County of Death				
cd/			LEVINDALE HEBS  5. Social Security Number	st hirthday)	BALTIMO If Under 1 Year	ORE If Under 24 Hrs.	h	N/A 9. Birthplace (State or Foreign							
	Funeral Director		Months Days Hours Min. (Mor							Day, Year) Country) 11/1922 MD					
	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits			
	Man)	tor	MD N/A	TIMOF	RE				1 <b>∑</b> Yes 2□						
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	intry?			
	th wii	ral	2434 W. BELVE	DERE AVENUE			21215			USA					
	tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		. 13.1	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	. 1	<ol> <li>Race - Ameri Black, White</li> </ol>				
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the M-dical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Mar 3 🏿 Widowed 4 ☐ Divorced	If Yes Give	No		1 □ Yes 2 🖾 No	Specify:			Specify: WHI	TE			
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218	within 7 lene. than "r th Med	ple	Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	life.	DO NOT use retired	duning most of work d)	ing						
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and	be fill Hall Had out		17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle,	maiden S	,				
Maryland	should Ind Men		MAX  19a. Informant's Name/Relations	hin (Tyne Print)	£	ARUB	na Address (Street	ANNIE and Number or Rui	ral Route Numb	er City or		LDBERG			
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ē,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tra		20a. Method of Disposition		20b. Pla	ce of Dispo	esition (Name of matory or other plac ONTEFIORE	rel	Date		ation - City or T				
altimore,	Page nent o nt: If		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5				ONTEFIORE R HEBREW	08/2	2/2012	BA	LTIMORE	E, MD			
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_	= 50		IF FEMALE:	OZa If was autooms	nf prognan	04									
Box	eath c attend for us	sian/	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  Unknown    23c. If yes, outcome pf pregnancy  1  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)   9  Unknown							2	3d. Date of deli Month	very Day Year			
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or Vital	Physician; this certific	Be (	25. Was case referred to medica examiner?				I Out	26. Place of Dea	th (Check only o	ne)					
or	Physi this c	2	1 ☐ Yes 2 ☐ No 27. Mapner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji		R/Outpatier 28b. Time o		4 DANUTSING H	ome 5 ☐ Resi 28d. Describe			cify)			
uo	ding After funer	tion	Natural 5 ☐ Pendi	ig (Month, Da		Injury	Wor	k? Yes 2∐No	200. Describe	now injury	occurred				
Division	Atten deatl	fical	3 Suicide 6 Could	not be 28e. Place of in	ury - At hon	ne, farm, str					reet and Number or Rural Route Number,				
á	al or s after	Certification:	4 Homicide determined building, etc. (Specify)												
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (		ng Physician: To the best Examiner: On the basis of and manner s	of examination										
	To th withir To th comp	Me	29b. Signature and title of certific	10 1			29c. Licens	se number	2	29d. Date	signed (Month	h, Day, Year)			
			) / X	10/				177	5	0/	21/2	012			
			30. Name and address of person	1				Baltimor	e.MD	ı	,				
	Sta		31. Date filed (Month, Day, Year	32. Regist	rar's Signatu	ıre									
	Registr		AUG 2 4	2012 Sendia	, B.	gar	KN								
DH	IMH 17 Rev 1/2	001													

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 dent's Name (First, Middle, Last) Date of Dea Physician/ ragus Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9261 Marydell Road Ellicott City Howard 7. Age (In yrs. last birthday) Funeral Social Security Number If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) Director 218-14-7856 1 🗆 M 2. 🛛 F 87 12/25/24 Marvland Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Evaniner must be notified at Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1109 Gregory Avenue 21207 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Louis A. Bossert Valense Celest Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Daley / Daughter 9261 Marydell Road Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 5 1. Burial 2 Cremation 3 Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery! 8/21/12 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ End Stage (OPT) disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death cartificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director: Daga 2 should he Attended to the attending physician and Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 1 ☐ Yes 2 № 9 ☐ Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 & Other Specify'S home Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) nskajap ahumo 00057465 8/23/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MDZ1209 NSRAJAPAKSEMD 203 2835 SMITH AV 31. Date filed (Month, Day, Year) State AUG 2 Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM/18perFH, G930, 8/28/2012, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 23<sup>Day</sup> 2012<sup>Year</sup> Vernon Zephir 9:50a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1205 Farmview Road Pasadena Anne Arundel 8. Date of Birth (Month, Day, Ye Nov. 12, Social Security Number **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Hours Director 217-16-4037 1 XM 2 □ F 87 1924 Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Marvland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1205 Farmview Road 21122 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?
1 X Yes 2 1942 If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Black, White, etc. þ 2 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: 1981 white "natural". Yes, Give Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Pattern Maker Bethleham Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **Lillian Mary** William Zephir Crawford permit. Page 1 and 2 should Department of Health and M Important; If item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Zephir/son 1205 Farmview Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 08/24/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. of Furieral Service Licensee Stephanie Custer anani 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as gardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) villmonar Physician MIMIC Obstructive Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence on Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No should be detached for 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown 9 Unknown Part Il Gther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Konal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? Yes 2 No certificate 2 No 1 Tes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗖 No Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending iniury s after death. Accident Investigation M 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medieal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and litle Durust, 24, 2012 Medical 30. Name and address person who completed cause of death (Item 22s) (Type, Print) osadona. 15410 A-1 USOVAD 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G930 8/24/2012 JH
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24 2012 2:55AM ANGELINA Lachman AUGUST Medical 4b. City, Town, or Location of Death Reisterstown 4c County of Death Baltimore 4a. Facility Name (if not institution, give street and number, **Examiner** FutureCare at Cherrywood 8. Date of Birth
(Month, Day, Year)
March 7, 1920 Social Security Numbe If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 031-03-4235 1 🗆 M 2 💆 F **Director** 92 Massachusetts Usual Residence of Decedent Show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💆 No Reisterstown Baltimore Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 0 items 23a or ner must be n U.S.A. Funeral 21136 316 Main St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Clerical Worker Western Auto Be 18. Mother's Name (First, Middle, Maiden Surname)
Theresa Guerriero 17. Father's Name (First, Middle, Last) Angelo Christoferi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit**%) 17:36**State, Zip Code) 316 Main St. Reisterstown. MD. 21135 Department of Health an Important: If item 27 is 1 any injury or other transpondent 316 Main St. Reisterstown, MD. Sherry Rosensteen - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Maryland Veterans Cem. Aug. 29,2012 Owings Mills, MD. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD. 21117 Signature of Funeral Service Licensee Hand Elle Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CHRONIC OBSTRUCTIVE Immediate Cause (Final Onset and Death 33055 Pulmonar Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine cause. Enter Underlying
Cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed and burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) for in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by STEHOSIS AORTIC 2 No 3 Probably 4 Unknown Division of Vital Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy perform 1 Yes 2 No this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After injury Natural 5 Pending n 24 hours after death. The Funeral Director; Af bletely filled in by the funeral filled in by 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A64455 Z4 Z012 2088852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Son/iskury, Mary/nest 21802 KATUUSIN C. DIAMONA 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:12 p.m. Julia Williams Alvey August 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Solomons Solomons Nursing Center 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Davs Hours 02/02/19 Country)
Tennessee Director 578-28-2902 87 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland | Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1066 Stagecoach Trail United States 20657 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Hygiene. other than "natural", 3 X Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H marked o ည Christopher Harris Williams Gladys Virginia Walter t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul R. Alvey, Jr./Son 14515 Woodcrest Drive, Rockville, MD 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or or 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 08/17/2012 Charlotte Hall, MD 21. Signatura of Funeral Service Liberated Artivasci M00872 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician, Atheroscierotic Cardio vas culan disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Dav 5 Other (specify) Pregnant at time of death 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hyporlipidemia 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 24a. Was an autopsy performe Yes 2 🔀 No 25. Was case referred to medical examiner?

1 Yes 2 No æ 26. Place of Death (Check only one) Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 

✓ Nursing Home 5 

☐ Residence 6 

☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) injury ✓ Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Property Process 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 50653 Man GYAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C 5851 Rond -

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

AUG 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per INF G93 Popular JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ST Margaret Quinlan Ahlborn ocation of Death If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 □XF 78 04/01/1934 Detroit, MI 10c. City, Town or Location Charles Brandywine 1 Tes 2XXNo 10f. Zip Code 10g. Citizen of What Country? 17275 Creekside Drive 20613 **IISA** 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? If Yes, Give Year or Dates 1 Yes 2X No Specify White Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Secretary Dept. of Navy 18. Mother's Name (First, Middle, Maiden Surname) Ellen Mundorf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17275 Creekside Drive, Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) Brinsfield-Echols Crem 08/11/12 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. #M00817 30195 Three Notch Rd., Charlotte Hall MD Approximate Interval Between Onset and Death COPD Due to (or as a consequence of) Due to (unawa nonsequence of Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 26. Place of Death (Check only one) 2 1 No Inpatient 2 🗆 ER/Outpatient 3 🗐 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending injury Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

Medical Facility Name (if not institution, **Examiner Funeral** 1-60026 291-28-3127 **Director** or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Directo MD 10e. Street and Number should be filed within 72 hours after death with t and Mental Hygiene.

is marked other than "natural", or items 23a Funeral 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 3 Widowed 4 X Divorced Completed 56400t-W Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 2 permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. William Quinlan Ahlborn 19a. Informant's Name/Relationship (Type, Print) Susan\_Eshleman / Daughter 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ ther (Specify) 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ahlborn, MARGA Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events burial-t resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: use 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown for signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Completed has page 2 25. Was case referred to medical Be examiner?
1 \sum Yes Certificate: To 27. Manner of Death 1 X Natural 24 hours after death Funeral Director: A 2 Accident 3 ☐ Suiciae 4 ☐ Homicide filled in by Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2.

To the F To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 069566 8-9-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20646 aplata, MD MichelMD5 Garrett Avenue 31. Date filed (Month, Day, Year) State **AUG 1 5 201** Registrar

Physician/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Estera ACHTENTUCH 4 2012 9:35 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery <u>Rockville</u> Hebrew Home of Greater Washington 8. Date of Birth Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Year 578-58-6021 1 - M 2 XF Dec. 12, Director Poland 1922 89 10c. City, Town or Location 10d. Inside City Limits 10a. State at Funeral Director must be notified 28a-f 1 Yes 2 X No Arlington Arlington Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 United States 23a 22201 2615 - 9th Street permit. Page 1 and 2 should be filed within 72 hours after death with Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, ral", or iten Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🛛 No Specify: Specify "natural" 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk Bakerv Be 18. Mother's Name (First, Middle, Maiden Surname)
Gretel Rackover 17. Father's Name (First, Middle, Last) ဂ္ Samuel Tashimowicz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8220 Rainbowview Place, Montgomery Village, MD Samuel Ashton, Son 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ō Department o Important: If any injury or 08/05/12 Adelphi, MD Lebanon Cemetery 4 ☐ Donation 5 ☐ Office (Specify) Tomohainskys Hebrew Funeral Home 20012 254 Carroll St., NW, Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Foot disease or condition resulting in death) Medical Due to lor as a consequence of) Examiner 2000 Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events 2 MIN To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician the buri Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Live Birth 2 ☐ 1 sea. ☐ Pregnant at time of death Ectopic pregnancy for Month Day 5 Other (specify) should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy performed? Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 \( \text{Yes} 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this of prompletely filled in by the feath. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending
Investigation injury work? 1 ☐ Yes 2 ☐ No Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 [ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, to 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

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Montrose

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:47 Elizabeth August Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) **Director** 215-38-4225 1 M 2 X 70 Sept. 9, 1941 Washington, DC 28a-f show 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Ves NO Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? Funeral 21 Yeatman Court 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married þ White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Arthur P. Myers Angela Girimonte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael F. Audet/Husband 21 Yeatman Court, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 Burial 2 K Cremation 3 Removal from State Alexandria, VA 4 Donation 5 Other (Specify) Metropolitan Crematory 22. Name and Address of Facility
Francis J. Collins Funeral
500 University Blvd. W., S 21. Signature of Funeral Service Licensee Home ilver Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between 23a. Part 1 Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): **Examiner** Bronchiolitis Obliterans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 2 🗌 No 1 Yes 2 XN 1 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. work?
1 Yes 2 No injury 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 10 D60826 August 7, 2012 who completed cause of death (Jen 23a) (Type, Print)
D 1500 Forest Glen Road, Silver Spring, MD 20910 Kshama Garg, MD Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 09 2012

DHMH 17 Rev 06-201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/  $\mathbf{Julv}$ 30, 2141 P M Baumgardner Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital Elkton Cecil 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F 212-44-7279 Months Days Hours 05/10/1947 65 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10d. Inside City Limits Funeral Director MD Cecil Elkton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Spanish Bay Court 21921 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinery Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever မှ Leroy Baumgardner Laura Bressler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla Ann Baumgardner / wife 3801 Spanish Bay Court, Elkton, MD 21921 tant: If item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 Lake View Memorial 08/03/2012
Park 1 X Burial 2 Cremation 3 Removal from State Important: I any Injury o Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility Strano & Feeley Family Funeral Home 635 Churchmans Road, Newark, DE 19702 Ement à 23a. Part 1. Enter the disease, proprietions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ B. C=11 disease or condition resulting in death) Lange MEars Medical or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Mellitus, Hypertension 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at ospital or Attending P I hours after death. uneral Director: After t 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check DO044313 MD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste A, Rising Sun, MD 21911 101 Colonial Way 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e per FH FCHD TM 8/9/12
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ August 5. Elaine C. Barman 4:40 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 144-50-5942 1 🗆 M 2 🖾 Director 57 Oct.12, 1954 New Jersey Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location Director Maryland Frederick 1 Yes 2 2 No New Market 10e. Street and 172 be Edwardian Lane 10f. Zip Code 10g. Citizen of What Country? Funeral United States 19572 Edwardian Lane 21774 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married δ 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) +2 Office Manager / Recruiter Information Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Is marked of Kicenska Edmund Schwartz Frances permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 Is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10572 Edwardian Lane/ New Market, Maryland 21774 Ajit Barman / Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 08/08/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart hailure. List only one cause on sech line. Approximate Interval Between CANCER Immediate Cause (Final PAN(CREATIC Physician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) , Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year ned by the at e detached fo Pregnant at time of death 9 | Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy After this certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director. After this certifice completely filled in by the funeral director, 1 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospice<sub>House</sub> Other: 4 Nursing Home 5 Residence 6 K Other (Spec 2/ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street an Number or Rural Route Number, City or Town, State Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The little and place and place and place, and due to the cause(s) and manner stated.

The little and place are place and manner as stated. 29a. Certifier (Check 29b. Signature and 30. Name and address of person who completed cause of death (Item 4 tex 4 BOCAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG Registrar

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #7 per DVR G930 8/30/12 dk. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 3 Day Physician/ 2012<sup>ear</sup> Clyde Neese Bell 2:05 a. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cecil 2614 Red Toad Rd. Rising Sun Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 □ F Hours Min 1/20/1930 Country) DE Director 222-18-3527 82 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21911 USA 2614 Red Toad Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Force Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give 3 - Widowed 4 - Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Electa C. Dodson Joseph O. Bell Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2614 Red Toad Rd. Rising Sun, MD 21911 Hildegard Bell/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 18/7/2012 Rosebank Cemetery Calvert, MD eral Service Licensee R.1.Foard Funeral Home, P.A. 111 S. Queen ST. Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): 16 -transit Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🗶 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?
1 \sum Yes 2 \sum No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 2 Accider injury 5 Pending Investigation 1 Yes 2 🗌 No Accident Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062190 3 0 MD 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA HNAWAZ KHAN MD SUITE A, CHESAPENICE CITY AUGUSTINE HERMAN HWY,

DHMH 17 Rev 7/2009

State Registrar 32. Regis rar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 9:15 A M Elma Ann Brooks August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cecil 107 Lincoln Avenue E1kton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 1 🗆 M 2 🖾 F Days Hours 7/16/1924 Director Yrs. 214-20-7259 88 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 K Yes 2 No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 Lincoln Avenue 21921 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give ould be filed within 72 hours after and Mental Hygiene. marked other than "natural", or Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner / Operator Supply - Western Auto Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ludwig Sheppard Edna D. Flanegan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Joan P. McKeown - sister Lincoln Ave. Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/1072012 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify Rising Sun, MD R.T.Foard Funeral Home PA . Signature of Funeral Service 22. Name and Address of Facility R.T. Foard Funeral Home, PA 259 E. Main Street, Elkton, MD 21921 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the failure. List only the cause on each line. Immediate (Final disease or indition Onset and Death Physician/ A-pirated pneumoni Medical resulting in death) Due to (or as a consequence of): Examiner DPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last CH7 burial-transi and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown been signed by the atte should be detached for Month Year Day Pregnant at time of death Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? 2 🗌 No 2 3 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 Yes 1 Natural 2 Accident 3 Suicide 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State,

Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certificate | completed filled in by the funeral director, Medical 29a. Certifier contriving Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cles 12 MI) DO 4623 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) main st, CHIH 31. Date filed (Month, Day, 32. Regis far's Signature

EKAM, Md 21921

Registrar DHMH 17 Rev 7/2009 Biomberg; Ronald

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			State of Maryland / Department of Health and Mental Hygiene  1 - State   Certificate of Death   Ben No. 2   1											12	2	710		
			Registrar  1. Decedent's Nam	e (First, Middle,	Last)		2. Date of							Reg. No. 2 3. Time of Death				
	Physicia Medic				e Blomber						Month		ay 2	ear	33	OPM		
	Examir	ner	4a. Facility Name (if	not institution, g		nber)		4b. City, Town	, or Location anham	of Death	9	4	c. County of		Coord	7010		
	Funeral		5. Social Security N	umber 6		7. Age (In yrs.	last birthday)	If Under 1 Year Months Day	ar If Unde	er 24 Hrs.	8. Date of Bi			ince George's  9. Birthplace (State or Foreign				
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1	e Mary r 28a-1 notifie	Sirec	MD 10e. Street and Nur		George's	5	]	Bowie			1   Yes 2 □ No  Citizen of What Country?							
	with th	Funeral Director	2823 Bo			10f. Zip Code	, 20715			10g. C	itizen of Wh US		try?					
	death items ner mu		11. Marital Status	dent Ever in U		Vas Decedent of Yes, specify Cu	Hispanic O	rigin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - American Indian,							
336	after al", or Examil	d by	1 ☐ Never Marr 3 ☐ Widowed		d 1 Vos	2□No e itesMarin	No.							Black, White, etc.  Specify: White				
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12	ithin 73 ene. • than he Me	Som	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ College (1-4 or 5+) Architect							mg	R.,	ildin	~					
	filed wall Hygi I other vent, t	Be	17. Father's Name (	First, Middle, Las							e (First, Middle	Building  le, Maiden Surname)						
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Mai	2 shorth and the and 27 is not traum		19a. Informant's Na	•	o (Type, Print) berg – Wi	ife		ng Address (Stree Boswort						te, Zip C	ode)			
ore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp	position		20b.	Place of Dispo	sition (Name of			Date Date		_ocation - C	ity or To	wn, State			
Baltimore,	ment trant: It tant: It jury or		4 Donation	5 Other (Sp		State	Green	natory or other p field	lace)	8-10	)-2012	Goo	ch1an	1. V	Α			
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1	Medical Examiner		resulting in death)	- 1	Due to (	or sa consec	uence of):	A-b-		)(a	٠.٥							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 05 Day SEAN IOHANNES BARRESI  $P^{M}$ AUG 2012 3:35 Medical 4a. Facility Name (if not institution, give street and number) WALTER 4c. County of Death Examiner 4b. City, Town, or Location of Death BETHESDA MONTGOMERY REED NATIONAL MILITARY MEDICAL If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** XXM 2 D F Months Hours Min (Month, Day, Yea, 8/4/2012 N/A Director MD Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director XX Yes 2 No MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d Mental Hygiene. marked other than "natural", or items 23a e matic event, the Medical Examiner must be Funeral 21401 608 Melvin Ave. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc 1XXNever Married 2 Married Completed by Baltimore, Maryland 21215-0036 xxes 2 □ No Specify: Puerto Rican White 3 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ John F. Barresi, Jr. II Isabel Vanessa Narvaez Dumas other traumatic and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Page 1 and 2 John F. Barresi, Jr. II Father 608 Melvin Ave. Annapolis, Md 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot ☐ Burial ※ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 8/8/2012 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph, ician/ SEPTICEMIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner EXTREME PREMATURITY Surroug distly flet out 1911 on Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) be detached Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 XNo has 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home 5} \( \text{Residence 6} \( \text{Other (Specify)} \) P 2**X** No 1 🗌 Yes 1 N Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of completed filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, D0054927 08/06/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)WALTER REED NATIONAL MILITARY MEDICAL CENTER JERRI CURTIS, MD BETHESDA, MD 20889

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month. Dav. Year

AUG 0 8 201

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Eacility Name (f not institution, give street and number) Examiner 4c. gty of Death a Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex. 1 ■ M 2 □ F Months Hours Min. Country **Director** 507-54-0047 78 Yrs 09/07/1933 Panama Usual Residence of Decedent or 28a-f shoy 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 X Yes 2 No Maryland Carroll Sykesville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 710 Obrecht Road 21784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 hours after 1 X Yes 2 ☐ No Specify: If Yes, Give "natural". Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates Panamanian permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medi-al E 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Department Chair Colgate Univ Sociology Department Elementary/Seconday (0-12) College (1-4 or 5+) Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Simon J. Bryce Myra Celestina Laporte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10709 Jamaica Drive, Silver Spring, Maryland 20902 Camila Bryce-Laporte/Daughter timore. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 8/14/12 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between s and eath Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): and Due to (or as a consequence of) resulting in death) Last Physician/Medical physicia that the death certificate be Box 68760 the as attending F FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? ò Day Year Pregnant at time of death the 9 Unknown 9 Unknown P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Deen O 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s autopsy performed? ate 1 ☐ Yes 2 No 1 X Yes 2 □ No certifica Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Tyes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Natural 5 Pending injury thin 24 hours after death.

the Funeral Director; After mpleted filled in by the fun 1 Typs 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2
To the comple only one) 29b. Signatu 110 Name and address of person who completed cause of death (Item 23a) (Type, Print) 2178 R el 2 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ Month Bielobocky August 4, 8:00 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Funeral 8. Date of Birth 166-30-0419 Months Days Hours (Month, Day, Year) Min. Country) 80 Director 1 M 2 □ F July 13, 1932 Pennsylvania Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 Yes 2 K No 10f. Zip Code 10g. Citizen of What Country? 5840 Shookstown Road Funeral 21702 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married within 72 hours after ģ 1 ☐ Yes 2 ☐XNo Specify: white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5+<sup>College (1-4 or 5+)</sup> Elementary/Secondary (0-12) Dentist Denistry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill be fill be fill be fill the fill the fill be fill from 27 is marked ည Joseph Bielobocky Leopolda Kraszesski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5840 Shookstown Road, Frederick, Maryland Marian Bielobocky - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery 8-6-2012 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aortic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) Month Day ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has autopsy or Attending Physician: The perform 1 Yes 2 No ours after death.

eral Director: After this certific.
filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral D Medical 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely f 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D43091 8-6-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zaid, MD 801 House Ave Torc and

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

recen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ July 2012 Elaine A. Brown 3:40 p.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 158-36-2556 **Director** 66 1 □ M 2 🔏 F 08/26/1945 New Jersey 2 should be filed within 72 hours efter death with the Maryland th and Mental Hygiene.
27 is marked other then "neturel", or items 23a or 28e-f show treumatic event, the Medical Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 787 Wembly Dr. Apt. E 21701 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Accountant Hotel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara R. Crawford / friend 8416 Foresight Lane, Walkersville, MD 21793 other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e
Department of I
importent: If ite
eny injury or ot
once. 4 Donation 5 Other (Specify) Stauffer Crematory 8/7/2012 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. MO1222 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ ATHERO SCLENOSI ONONM-1 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physicien and for use as the burial-transit thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate 1 ☐ Yes 2 No 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica Division of Vital ours after death.

erel Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at / work? 1 🗌 Yes 2 🗌 No 1 Natural 2 Accident 3 Suicide 5 Pending injury Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) -30-2012 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK KAZmi A. Toll House Ave MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bonanni Pasquale July 29 3:01P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Annapolis** Anne Arundel Medical Center Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 577-40-0883 1 X M 2 □ F 85 2/6/1927 Italv 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland Queen Annes Stevensonville 1 🗆 Yes 2 ဳ No 10f. Zip Code 10g. Citizen of What Country? Funeral 308 Queens Court 21666 **USA** 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Executive Chef US Capitol Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ Ignazio Bonanni Ines DiMichele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tractore. Anna Bonanni/Wife 308 Queens Court, Stevensonville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem'l Gardens 8/3/2012 4 Donation 5 Other (Specify) Davidsonville, MD permit. 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 21. Signat of Funeral 8 alax ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease shock, or heart failure. e, or complica List only one o Approximate Interval Between Immediate Cause (Final Onset and Death Pny ician/ Medical Itasion disease or condition resulting in death) **Examiner** Sequentially list conditions, if any leaf in in a leaf cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of burial-trans resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nume Prantificance. To the basis of my including, death occurred at the time, date and place, and due to the cause (s) and manner stated (Check 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type 71401 31. Date filed (Mor Registrar's Signature State 01 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Betty Lou Cleary August 1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital of Cecil County Cecil Elkton Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Months Min. Month, Day, Year) ine 15,1931 Hours West Virginia **Director** 215-42-7229 81 Yrs. Usual Residence of Decedent 3a or 28a-f show t be notified at 10a, State 10b. County 10c. City. Town or Location Director Maryland Ceci1 North East 10e. Street and Numbe 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a.
any injuny or other traumatic event, the Medical Examiner must b Funeral 24 Creedmore Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Completed 3 Divorced 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Sydenstricker Mary Pauline Priest 19a. Informant's Name/Relationship (Type, Print) J.B. Cleary / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State Norther East of the leave August 6, 4 Donation 5 Other (Specify) Signature of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ erebrovascolar accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner to Ure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine ension attending physician and for use as the burial-transit ner that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No led by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Fibrillation Clostridium di Records, Completed 24a. Was an page 2 s autopsy performed? Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident Investigation M ☐ Acciden
☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Creedmore Lane, North East, Maryland 20c. Location - City or Town, State North East, Maryland 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland 21901 Interval Between Onset and Death .011 2012 2 2011 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔼 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) > Albelow & Madowy, M.D. D0059223 august 1, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Melcher F. Madarang, M.D. 215 North Street, Elkton, Maryland 21921 31. Date filed (Month, Day, Year) AUG 0 6 State Registrar DHMH 17 Rev 7/2009 ORIGINAL

15:55 PM

10d. Inside City Limits

White

1 Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 4:45 P M 08 Elizabeth Conrov Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Carroll Carroll Lutheran Village Healthcare Westminster Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. (Month, Day, Year) 111-28-4942 Director 1 🗆 M 2 😾 F 100 04/16/1912 Ireland show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or 28a-f sl e notified MD 1 X Yes 2 ☐ No Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be permit. Page 1 and 2 snouru us more.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a in mortant: If item 27 is marked other than "natural", or items 23a in mortant. Funeral 300 St. Luke Circle 21158 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugh Watson Elizabeth Nixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Conroy/daughter 5920 Barbados Place, Box 203, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/03/2012 Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Pritts Funeral Home and Chapel Me. 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 2 No 1 🔲 Yes 은 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 🗌 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be filled in by the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2 To the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated who completed cause of death (Item 23a) (Type, Print) 5 300 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G931 9/06/2012 Jh State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year **Physician** August 1, 1:45 p M Anne Conrad /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick St. Joseph's Ministries Emmitsburg 8. Date of Birth (Month, Day, Year)
Sep 22, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 2915 5821 3725 174-16-9206 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Days Hours Min 1 □ M 2 🕽 F Months 94 Yrs. า๊917 Director Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinar must be notified at Frederick Emmitsburg 1 ☐ Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21727 7243A Friends Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 11 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Drabish Mary Salabaj 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Ford, daughter 16909 Eylers Valley Road, Emmitsburg, MD 21727 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of ceme@popuringtory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 8/3/2012 Winfield, MD Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature | Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans and resulting in death) Last Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

-5

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

29b. Signature and title of certifier

AUG Xear)

3

31. Date filed Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) /

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 11:46 PM James Richard Czzowitz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death St. Mary's 37629 Beverly Drive Mechanicsville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Year) **Director** 160-30-0725 1 X M 2 🗆 F 04/07/1938 Bruin, PA Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits notified at Director Maryland St. Mary's Mechanicsville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 20659 37629 Beverly Drive USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates 2 No Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: White 3 ¥ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) U. S. Air Force Flight Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Peter Czzowitz Mary Mostowy Czzowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 7301 E. Calle Lugo Tucson, AZ 85710 <u> Jerald Czzowitz / Son</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ermetery, crematory or other place Brinsfield-Echols Crematory Date 1 Burial 2 T Cremation 3 Removal from State 08/10/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) rematory Signature of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols Funeral Home M00817 30195 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician) disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death the a signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 certificate 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No or A. As after dea.
In Director: At a by the Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined filled in I 24 hours Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 06-2011

AUG 1 3 2012

30. Name and address of p

<u>Jennifer</u>

on who completed cause of death (Item 23a) (Type, Print)

Registrar's Sign

.D

Schmidt,

10055

MD 20650

40900 Merchants Lane, Leonardtown,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day August 14, 2012 Frank T. Crowe 12:08 ⊉ ™ 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Garrett Goodwill Minnonite Home Grantsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours 1 X M 2 ☐ F 219-14-6889 Pennsylvania 92 23, 1920 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Frostburg 1 ☐ Yes 2 No Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 U. S. A. 2315 Finzel Road 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No 19 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1943 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 ☐ Divorced White 1945 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Automotive Service Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Edward Crowe Clara (Wolf) Crowe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3968 Greenville Rd., Meyersdale, PA Eileen McLaughlin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Emmanuel Meth Church Aug 17 2012 Frostburg, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hafer Frost Mansion Frostburg, MD 58 Frost Ave. Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spack, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23d. Date of delivery egnancy Month Year Dav ecify)

**Physician** /Medical Examiner

attending physician and for use as the burial-trans

been signed by the should be detached

certificate has lirector, page 2 s

the Funeral Director: After this certific ompletely filled in by the funeral director,

the Hospital

**Physician** 

**Examiner** 

**Funeral** 

Director

is 23a or 28a-f show

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

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other than "natur

27 is marked of traumatic even

0 permit. Page Department of Important: If any Injury or once.

Health a

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Physician/Medical ģ Be Certification: To

l or Attending Physician: The law requires that the death certificate be executed after death.

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tirn 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pr 5 ☐ Other (spe
Part II. Other significant condition			
25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpat	ient 3 □ DO

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	23e. Did tobacco us	se contribute to the cause of death?
	1 ☐ Yes 2 ☐	No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 □ Yes 2 □ Vo	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No
	01 1 1	

							1 ∐ Yes	2 1340	1 Li Yes	2 ∐No
25. Was case reference examiner?	red to medical				26.	Place of Deat	th (Check only o	ne)		
1 Yes 2	No	Hospital: 1 ☐ Inpatient 2	Nursing Ho	Home 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of De the San	5 ☐ Pending investigation		28b. Time of Injury	M 280	c. Injury at Work? 1 □ Yes	2 □No	28d. Describe h	ow injury o	ccurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, street ec <i>ify)</i>	t, factory, c	office		28f. Location (S City or Tow	itreet and N n, State)	umber or Rura	l Route Number,
29a. Certifier (Check only	1 Certifying Ph	nysician: To the best of my niner: On the basis of exam	knowledge, death on nination and/or inves	occurred at stigation, i	t the time, d n my opinio	ate and place n, death occu	, and due to the rred at the time,	cause(s) an	nd manner as s ace, and due to	tated. the cause(s)

comb	Me	29b. Signalize and title of certifie
$\sim \times 1$		30. Name and address of person
		margaret a

State Registrar 130

and manner stated

32. Registrai

Amend No. 10e, AACO Health Dept	19	8 per FD 8 8 12 KAH	Pleas	e Type or Pri							_		_	ble.		
How itelian ap	 1	For State		State of M	aryıan		artmen tificate			and N	1ental Hy	gien	e 20	12	27	119
		Registrar  1. Decedent's Name	e (First, Middle, L	ast)		Cer	uncau	e OI L	- aui		2. Date of De	Reg. N	lo. <u>Z</u> U	1 4	3. Time of D	110
Physician/ Medical		PIYAL	E			CE	RM	AN	/		8.8	_	8 2	Year 0/2	OOLL	
Examiner		4a. Facility Name (if	not institution, gi	ve street and number)			4b. City,	Town, or	Location	of Death			c. County of	f Death		
·				E HOSPICE				RWOOI					NNE AI			
Funeral Director	- 1	5. Social Security No.		Sex 7. Ag 1 ☑ M 2 ☐ F	e (In yrs. la	st birthday)	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birth Coun	olace (State or F try)	oreign
		Usual Residence o		TAJM 2 L F	82	Yrs.					10/01/1	929	7	ΓURK	EY	
/land f show ed at	Į	10a. State	10b. County		10c. City	, Town or Loc	cation							1	0d. Inside City	Limits
e Mar 7 28a- notifie	<u> </u>	1ARYLAND	ANNE AR	UNDEL	ARN	OLD									1 🗌 Yes 2	X No
leath with the Maryland tems 23a or 28a-f sh ermust be notified at Finneral Director	6	10e. Street and Num ASQ	HTIUC				10f. Zip					10g. (	Citizen of Wh	at Cour	ntry?	
ems (	5	_1251 ASQU 11. Marital Status	UILLA DR	12. Was Decedent I	Ever in U.S	5. 13. V		1012 Sent of His	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		TTED S			
fter de mine		1 Never Marri	ied 2 Married		No		Yes, spec				Rican, etc.)			White,		
OO3 burs at tural" al Exa	3	3 Widowed		If Yes, Give Year or Dates.									Specify:	WHI	TE	
21215-003 hithin 72 hours ar lene. r than "natural" the Medical Ext	1			grade completed)			ent's Usua and of wor NOT use	rk done d	ation luring mos	t of worki	ng	16b.	Kind of Busi	iness/In	dustry	
212 within giene.		Elementary/Seco 12	ondary (0-12)	College (1-4 or 5	5+)	PHYSI			)			l P	SYCHIA	TRY		
Ind 21215-0036  filed within 72 hours after death with the Manyland tall Hygiene.  ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at the Re Commission Beautified at the Research of the Rese		17. Father's Name (F	First, Middle, Las	1)		-		ĺ	18. Moth	er's Name	(First, Middle,					
Maryland should be file n and Mental I 7 is marked o raumatic eve	١.	NERMI CEI	RMAN						MELE	HAT	(uiik)					
Maryland 21215-0036  2 should be filed within 72 hours after lith and Mental Hygiene.  27 is marked other than "natural", o retaumatic event, the Medical Exam.  To Be Completed by	- 1	19a. Informant's Na		(Type, Print)							l Route Numbe			te, Zip (	Code)	
d de E	- 15-	ANN CERMA 20a. Method of Disp			20h P	1251 lace of Dispos			RIVE		NOLD, M			its or To	Ptete	
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe		1 ☐ Burial 2.		Removal from State	CHÉ	SAPEAK	E CRE	MATI	on .				Location - C	-		
Baltil permit. P Departm Importal any Injury	t	21. Signature of Fur			ICEN'	22			s of Facilit	8/9/2 yLAS:	ZUIZ TING TR	IBU'	EVENSV FES BY	FE	LLOWS	
Bal permi Depar Impo any Ir	1	SK	AK	/.		B	ELFEN 14 BE	BEGA	TE R	EWNAI	<sup>1</sup> ANNAPO	TI81	MD FL	YER 140	AL CARE	
	1	23a Part 1. Enter the shock, or hear	he disease, or co t failure. List only	mplications that caused one cause on each line	the death	n. Do not ente	r the mode	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betwe	en
Physician/	ì	Immediate Cause (I		. KES	PIRA	FTORY	F	AIL	URE	-					Onset and Dea	
Medical Examiner	1	resulting in death)	•	Due to (or as			20001								2000	
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xecuted n and al-transit		cause. Enter Under Cause (Disease or i that initiated events	flying injury		A	FAR	ICR	EA	S						WEEK	<5
9 .0 5	i I	resulting in death) L		Due to (or as	a consequ	ence of):										
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Box 68760 death certificate be the attending physical for use as the the scientificate be some for use as the the scientificate beautified to the scientificate beautificated to the scientificated	1	F FEMALE: 23b. Was decedent	prognant	23c. If yes, outcome	of pregnar	ncv										
eath of attendation	ľ	in the past 12 n	nonths?	1 ☐ Live Birth 4 ☐ Pregnant a	2 Fetal	I death 3	Ectopic p		У				23d. Date Month		ery Day Yea	r
the d the by the tacher	}	9 Unknown		9 🗌 Unknown												
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours affer death. To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the butter that the funeral director. Be Completed by Physician/Medical Certificate: To Be Completed by Physician/Medical		Part II. Other signifi	icant conditions	contributing to death b	ut not resu	ulting in the u	nderlying o	cause give	en in Part	l.					e cause of deat	
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Vital hysician nis certifi I director	Ī	examiner? 1 ☐ Yes 2 €	No	Hospital:	ent 2 🗀 I	ER/Outpatien	1 3 □ DC	Otho	r.		me 5 🗆 Resi	dence	DAN	DRI	NINPI	- (TD
of ng Ph Iter th Ineral		27. Manner of Death	5 Pending	28a. Date of inju	ry	28b. Time of injury		8c. Injury work?	at		28d. Describe		ry occurred	<i>эреспу,</i>	CAICE	CIII
ion tendii beath. tor: At the fu		2 Accident	Investigati	on			М	1 🗆 '	Yes 2 🗆	No						
Division of Vital Records, all or Attending Physician: The law requires is after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be to be the funeral director.		4 Homicide	determine		ry - At hor :. (Specify)	me, farm, stre	et, factory	, office			28f. Location (\$ City or Tov			or Rural	Route Number,	
Di the Hospital in 24 hours a the Puneral to the Hospital (illed	ŀ	29a. Certifier	Certifying Pf	nysician: To the best of	my knowle	edge, death o	ccurred at	the time	. date and	place, ar	d due to the c	ause(s)	and manner	as state	ed.	17
in 24 l he Fu he Fu pletel		(Check 2		miner: On the basis of e	xamination	and/or investi	gation, in r	ny opinior	n death oc	curred at	the time date a	and place	e and due to	the car	se(s) and manne	er stated.
Vith Con		29b. Signature and t	title of pertifier	1-20	A	· im	29c.	. License	number	200		29d.	ate signed (//	Nonth, L	Day, Year)	
		2M	Mail	1000	W 14	1 - 1		DI	V14.	38		1	ugu	N	08 201	2
		30. Name and addre	ess of person wing	completed cause of de	eath (Item		int) ENSE	Ha	J. A.	VAJA	POLIS 1	MD	214	0.1		
State	1	31. Date filed (Month	h, Day, Year)	32. Registra	ır's Signatı		-1476		1/1/	- +0//	1	9	VIT	<i>V</i> !		
Registrar	L	AU	6 U 8 201	4 Penns	. 1.	has	1									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 4, Day 2012 Year Daisy B. Carr 4:40 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3205 Apple Green Lane Prince George's Bowie 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Hours Feb. 16, Year) 924 579-48-2563 Director 1 M 2 X F 88 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** must be notified MD Prince George's Bowie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 20716 USA 3205 Apple Green Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ral", or iter Examiner 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 18. Mother's Name (First, Middle, Maiden Surname)

Daisy Bussey 17. Father's Name (First, Middle, Last) ပ Chester Little 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3205 Apple Green Lane. Bowie, MD 20716 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health a item 27 i 3205 Apple Green Lane, Bowie, MD Patricia Rauch / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 X Removal from State 8/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Bethel, NC Council Cemetery 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 var 1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sprock, or heart failure. List only one cause on each line. Approximate Interval Between Inmediate Cause (Final Physician/ ALTHEIMERS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes HYPERLIPIDEMIA OSTEOPOROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Hospital or Attending 24 hours after death. 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fu Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce lifier 0036091 eath (Item 23a) (Type, Print) and address of person who completed cause of

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month

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BESTGATE RD ANNAPOLIS MD 21401

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene
			1 - State Registrar Certificate of Death Reg. No. 20 2 27 20
	Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Vear O7 30 2012 9:00 A. M
-	Medi Exami		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
-	Famoust	,	12410 Gramlich Road, S.W.  LaVale  Allegany  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. Birthplace (State or Foreign)
	Funeral Director		190–28–2282 1V M 2 D F 77 V Months Days Hours Min. (Month, Day, Year)
	nd how at	ا ا	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10d. Inside City Limits
	Maryla 28a-f s otified	irect	MD Allegany LaVale 1 □ Yes 2 X No
	ith the	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	eath w tems 2 er mus	une	12410 Gramlich Road, S.W.  21502  U.S.A.  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Reach White etc.
9800	e filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces? 1 No Fyes, 2 No Fyes, Specify:  If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.  1 Yes 2 No Specify: White
15-(	72 hou n "nat Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry  Kelly-Springfield
212	led within 72 Hygiene. other than ' ent, the Me		Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired)  12 Kelly-Springfield Customer Service Representative Tire Company
land	ould be filed of Mental Hyg marked oth matic event,	To Be	17. Father's Name (First, Middle, Last)  Clarence Henry Calycomb  18. Mother's Name (First, Middle, Maiden Surmame)  Madolyn Claire Hyde
lary	should be file h and Mental I 7 is marked o traumatic eve	in.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
e, N			Anita Lopez / Daughter 3704 N. Cedar Street, Zachary, LA 70791  20a. Method of Disposition (Name of Street)  20b. Place of Disposition (Name of Street)
Baltimore, Maryland 21215-0036	permit. Page 1 and Department of Heal Important: If item 3 any injury or other once.		1 Burial 2xxCremation 3 Removal from State 4 Donation 5 Other (Specify)  Cumberland Crematory 07/31/20/2  Cumberland, MD
Ba	Depar Impor any in		21. Signature of Funeral Service Johns.  22. Name and Address of Facility Upchurch Funeral Home, P.A.  202 Greene Street, Cumberland, MD 21502
H			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus of each line.  Approximate Interval Between
1	Ph_sician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Onge five left the left of ELIRSE
	Examiner		e to ( ) s a consequence of):
	ed sit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
	xecute n and ial-tran	Еха	that initiated events c.  resulting in death) Last Due to (or as a consequence of):
09	ate be executed hysician and the burial-transit	dical	d
687	ertifica ding pl	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy
Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No 9   Unknown   1   Unknown   23c. If yes, outcome of pregnancy   23d. Date of delivery   23d. Date of delivery
P.0.	s that the gned by be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
rds	require	eted	1 Yes 2 Mo 3 Probably 4 Unknown
Records,	sician: The law recertificate has b	Completed	24a. Was an autopsy findings available autopsy performed death?
Vital F	ian: Therificat	Be C	1   Yes   2   No   1   Yes   2   No   No   1   Yes   2   No   No   No   No   No   No   No
Ž	Physic this ce	은	1  Yes 2 No
o uc	nding ath. r: After re fune	icate	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M Investigation (Month, Day, Year)
Division of	or Atte after de Directo in by th	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Ω	sspital hours a meral l	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	the Ho	Medica	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	,		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
	/2	}	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	MRS		Gary Waggerer, M.D 925 Bishop Walsh Boad, Cumberland, MD 2/502
	Stat Registra	e r	31. Date fled (Month, Der Year)  32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ lizabeth 2:11PM ANN 2012 08 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Julia Manor Health C Harrestown Social Security Number If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 215-56-2747 Hours Country) Director 1 🗆 M 2 🔀 F 87 April 6,1925 Maryland 28a-f show 10b, County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland at 10d. Inside City Limits Director be notified 1 X Yes 2 No Maryland Washington Hagerstown 9 10f. Zip Code 333 Mill Street 10g. Citizen of What Country? 23a Funeral must 21740 USA Julia Manor Health Care Center or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Examiner Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", white 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed, than, Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Charles Henry Crum Ruth Ester Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Charles H. Crum, Jr.-brother 686 Lake Caroline Dr., Ruther Glen, Va. 22546 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olivet Cemetery 8/16/12 4 Donation 5 Other (Specify) Frederick, Maryland TFuneral Service I 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physicism/ chronic Kidner disease or condition resulting in death) Medical **Examiner** pertensive Egguentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No detached for Month Year Pregnant at time of death Day 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Retardation, Hypothy Roidism, Osteoarthrills 1 Tes 2 No 3 Probably 4 Unknown peripheral Vascular Disease Were autopsy findings available 24a. Was an Director: After this certificate has autopsy prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury work?
1 Yes 2 No Accident Suicide Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined Hospital c 24 hours a within 24 hours a Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

29d, Date signed (Month, Day, Year)

Mill Street, Haberstown, MD21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Summer Ella Clayton Physician/ 08 2012 7:36 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number **Funeral** Age (In vrs. last birthday Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 1 🗆 M 2 😿 F 08/07/2012 Maryland Usual Residence of Decedent 28a-f shov 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Prince Georges Takoma Park 1 Yes 2X No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7314 15th Avenue 20912 USA death v or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Examiner Armed Force Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural" 3 Widowed 4 Divorced Completed Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 0 Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. N/AN/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robertson Clayton Ann Maria Durham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7314 15th Avenue, Ann Maria D. Clayton Mother Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Page 1 g 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 08/11/2012 | Glen Burnie, Maryland 21. Signature Funeral Service Licens 22. Name and Address of Facility Cole Funeral Services, P.A. 4110 Aspen Hill Rd.#100.Rockville MD 20853 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Extreme Prematurity hours Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 XNo 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown maternal hypertension Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy perform Yes 2 X No 1 Yes 2 X No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No မ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural work? 1 🗌 Yes 2 🔲 No 5  $\square$  Pending iniury Accident Investigation 6 Could not be s after death Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature of certifie 29d. Date signed (Month, Day, Year) 0055448 08/07/2012 ress of person who completed cause of death (Item 23a) (Type, Print) Silver Srping, MD 20901 Audrey Μ. Seidel M.D 10801 Lockwood Drive #320. Date filed (Month) State

DHMH 17 Rev 06-2011

Registrar

reserve .

Back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ 2012 Richard Dvorak August 07:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2544 Singerly Road E1kton Ceci1 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday g. Birthplace (State or Foreign Date of Discourse (Month, Day Yes **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 218-72-1891 52 Mary land Director 1959 Sept. Usual Residence of Decedent 28a-f shov 10b. County notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No Maryland| Ceci1 E1kton 10e. Street and Number 10f, Zip Code ö 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 2544 Singerly Road 21921 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 ☐ Married ☐ Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. Automotive Repair and life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Service Owner/Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F 7 is marked of permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ Robert J. Dvorak, Sr. Kathryn Lorraine Magaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Dvorak/Brother 94 Carters Mill Road, Elkton, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) August 15, 4 Donation 5 Other (Specify) Immaculate Conception Cem. Cherry Hill, MD 2012 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. Stockton St., Elkton, MD 103 W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or I that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ☐ Live Βιττι ∠ ☐ , ..... ☐ Pregnant at time of death in the past 12 months? Month Day Year the g Unknown 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funeral 1 Natural 5 Pending 1 Tes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

HERMAN

AUGUSTINE

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2020 M Physician/ 06 TRU 703 16 -ILLIAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Inpatient Care Center Harwood Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days Hours 224-32-4156 Director 83 1 □ M 2 🕅 F 2/4/1929 Virginia Usual Residence of Decedent item 27 is marked other then "natural", or items 23a or 28e-f shov other treumatic event, the Modest Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Edgewater Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21037 1707 Shore Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16h Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health end Mental Hygiene. Importent: If item 27 Is marked other then any Injury or other treumatic event, Ite Me Elementary/Secondary (0-12) 8th College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Hassie Knick David H. Bennington 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 Shore Drive, Edgewater, Maryland 21037 Sandra L. DiPietro/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Lakemont Cemetery 1 X Burial 2 Cremation 3 Removal from State 8/10/12 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home Signatus / Funeral Service Licens 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGES Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or Exami ERUTTC use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificete be executed that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical 26. Place of Death (Check only one) Other (Specify) HUUSE Be MHAMPICIA examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description:

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certifier 60 pleted cause of death (Iten me and address of persol State

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Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick Street Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ (erebral Vascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Examiner Due to or as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ostridium Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Lev Ko cy tosis 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 2 No 1 Yes Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo ျ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Gertifying Nurse Practitioner: To the best of my knowledge, d at the time data and plane, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15/2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonard town MD

State Registrar

Dema

FRANK

31. Date filed (Month, Day, Year)

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Registrar's Signatur

nd/ Suite 207/40900 Herchants Lane

Box 68760 P.O. Records, • Hospital or Attending Physician: The 124 hours after death.
• Funeral Director: After this certificate heted filled in by the funeral director, page **Division of Vital** 

State

31. Date filed (Month, Day, Year) 12 Registrar

(Check

29b. Signature and title of certifier

Herlyn

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D26907

29d. Date signed (Month, Day, Year)

AUCUST 08, 2012

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) August Physician/ (245M Marie Therese Ehrlinger Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hagerstown Meritus medical Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthdav) Social Security Number **Funeral** Months Davs Hours 91 **Director** 073-16-0834 1 D M 2 DXF April 15,1921 New York or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County within 72 hours after death with the Maryland notified at Director 1 ☐ Yes 2X No Greencastle PAFranklin 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number must be Funeral 23a 17225 USA 2249 Grove Meadow Lane iral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. s, specify Cuban, Mexican, Puerto Rican, etc. <u>S</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White Completed 3X Widowed 4 ☐ Divorced 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Personal Residence Homemaker + Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Clara Marguerite Meltzer John Patrick Guadagnoli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2249 Grove Meadow Lane, Greencastle, PA 17225 David J. Ehrlinger / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I-Important: If ite any injury or oth cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Aug. 11,2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Signature of Funeral Service Licensee 1331 Eastern Blvd. N., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final USRTICIL Physician disease or condition Medical resulting in death) as a consequence of Due to (o Examiner Sequentially list conditions Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to the Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 38 attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed' 1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Division of Vital Records, funeral director, 

Certificate:

Medical

TW - 8

State

Natural

4 Homicide

only one 29b. Signature and title of cept

29a. Certifier

Accident

Suicide

5 Pending

Investigation 6 Could not be

determined

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CAMPUS RD, HAC

11116

iniurv

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 August 9:30 a. Calvin Emerick, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lorien of Mt. Airy Frederick Mt. Airy If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) 10/20/1936 Days Hours Maryland Director 218-34-4332 1 X M 2 E 75 Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No MD Frederick New Market 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6714 W. Lakeridge Road 21774 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 IX Yes 2 □ No
If Yes, Give Year or Dates 1955–63 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Specify: White 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College Administrator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Calvin Emerick, Sr. Edith Rowan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richelle Emerick/ wife 6714 W. Lakeridge Rd, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 8/7/2012 Frederick, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service License Regula 14 MO1222 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) MONO Medical Due to (or as a consequence Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) sulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 🔀 1 ☐ Yes 2 ☐ No . Was c referred to medical examiner? æ 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: ter of D 28c. Injury at 28d. Describe how injury occurred work? 5 Pending 2 🗆 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu eand title of certifie 29d. Date signed (Month, Day, Year) A Co 2012 10x1

State

Frederick, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

56 TJ Drive,

32. Registrar's Signature

Joseph Ashwal

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

	i leade Type of Tillt in Diack indelible lik. Elisale Al
Douglas Wayne Feiser	State of Maryland / Department of Health and Me

		1- For State Registrar	Certificate of Death	Reg. 1	Z U I	2 2113
Physic		Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
edical Exam	inei	Doug.las Wayne Feiser  4a. Facility Name (if not institution, give street and number)		Month Da August 15, 2		1954 hrs
		1 E. Water Street #7	4b. City, Town, or Location of Death Smithsburg	n	4c. County of Death Washington	
Funeral	5	5. Social Security Number 6. Sex 7. Age (In ye	rs. last birthday)   If Under 1 Year   If Under 24Hrs	s. 8. Date of Birth (1	MM/DD/YYYY) 9. Birt	hplace (State or
Director		220-78-6058 1XM 2 F 52	Yrs. Months Days Hours Min	July 18	,1960 Foreig	n <sup>Intry)</sup> Maryland
		Usual Residence of Decedent				
W an			City, Town or Location			10d. Inside City Limits
ne Maryland or 23a-f sbow any fied at once.	횼	Md. Washington  10e. Street and Number	Smithsburg	140-	Citizen of Mart of Co.	1 X Yes 2 No
r death with the Maryland or items 23a or 28a-f sbo must be notified at once.	Director	1 E. Water St. Apt. 7	21783	Tog. (	Citizen of What Coun	ury ?
with t ns 23a be not	E	11. Marital Status 12. Was Decedent Ever in		pecify Yes or No-	14. Race - Americ	can Indian, Black,
death or iter	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 N	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	240
s after ral",	<b>全</b>	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify:	ite
2 hour	ted	Decedent's Education (Specify only highest grade completed     Elementary/Secondary (0-12)     College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use retired.)		b. Kind of Business/Ir	ndustry
036 thin 7; ne.	Completed	.12	Upholster		Upholstr	y
5-0036 iled within 77 Hygiene. I other than		17. Father's Name (First, Middle, Lest)		e (First, Middle, Maid		
21215-0036 Juld be filed within 72 hours after Mental Hygene. marked other than "natural", ie event, the Mediral Txaminer.	Be C	Irexel E. Feiser  19a. Informant's Name/Relationship (Type, Print)		cia L. Tu		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 71 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Traminer must be notified at once.	ြို	Patricia I: Barnes (Mother)	19b. Mailing Address (Street and Number or I 13725 Meadow Creek La			
e, R I and Health Titem			b. Place of Disposition (Name of cemetery,		c. Location - City or	Town, State
MOTE Pages 1 ient of H int: If i		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		20,	Smithsbur	g Md.
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	22. Name and Address of Facility		525 Bradbu	ru Ave.
			MO1414 J.L. Davis Funera	1 Home Sm	ithsburg.M	d. 21783
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line.			shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerot Due to (or as a consequence)	cic Cardiovascular Diseas	se		Death
	_	Sequentially list conditions, b.				
	nine	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	e of):			
A RE	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)	a of):			
Records, P.O. Box 68760,  The law requires that the death certificate be executed, cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit		d.  X UNPENDED AMENDED 23a,pt	.II,27,per me,g933 11-16	_12 cm		
760, icate be ex physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pr			23d. Date of delivery	
687 ertifica ding p		23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna	1	Month D	зу Үеаг
Box 687 e death certific the attending ed for use as t	Physician	1 Yes 2 No 9 Unknown 9 Unknown	death 5 Other (Specify)			
O. Bo at the de		Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	ne cause of death?
S, P.O. luires that the signed by Id be detach	d by	chronic alcoholism		1 Yes 2	No 3 Proba	ably 4 🗹 Unknown
ords w requas beer shoul	plete			24a. Was an autopsy		opsy findings available impletion of cause of
tal Reco	Completed			performed 1 Yes 2	l? death? ]No 1 ✔ Yes	2 No
cian: certifi ector,	Be (	25. Was case referred to medical examiner?	26.Place of Death (Check of	<del></del>		
of Vital Records, ng Physician: The law require wher this certificate has been si meral director, page 2 should b	2	1 Yes 2 No Inpatient 2  27. Manner of Death 28a. Date of Injury	ER/Outpatient 3 DOA Other Nursin  28b. Time of Injury 28c. Injury at Work?	g Home 5 Resi	idence 6 🗸 Other:	Scene
Division of Vital F Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifitely filled in by the funeral director,	tion:	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	200. Describe flow i	injury occurred	
Division tal or Attendir ts after death. al Director: A led in by the fu	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - A	t home, farm, street, factory, office building, etc.		t and Number or Rura	al Route Number, City
Division of the hours after de inectal Direct y filled in by	Certificati	4 Homicide determined (Specify)		or Town, State)	)	
		29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination	edge, death occurred at the time, date and place, and n and/or investigation, in my opinion, death occurred a	due to the cause(s)	and manner as stated	d.
To the within To the complete	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	
	-	1/11/11/11	O.C.M.E. UCM		ugust 16, 2012	, July, 1901/
4		30. Name and address of person who completed cause of death (In	~ · · ·		- '	
Ψ		Theodore M. King, Jr., MD. Assistant Medica		altimore, MD 21	1223	
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ALFRED FOX AUGUST 06 2012 8:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Unde Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months Min. 312-46-7155 **Director** 1 X M 2 . F April 20 1936 Germany 76 Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 K No MD Frederick New Market 10e. Street and Number o 10f, Zip Code 10g. Citizen of What Country? Funeral ms 23a (must be 11711 Barnswallow Place 21774 USA items 2 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or i by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1960-72 1 ☐ Yes 2 🖾 No Specify: Specify: Completed 3 Divorced 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) electronic technician Naval photo lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o John Fox Erika Tonat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Fox/wife 11711 Barnswallow Place, New Market, MD 21774 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or ot once. 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 08/08/2012 | Frederick, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter 'te di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart a ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardiotulmonary disease or condition resulting in death) Medical Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy after death.

Director: After this certificate 2 No ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 10 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8.6-2017 D60417 OXY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemen Thomas Frederick MD 21702 Shah C TUHNSON 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	arylan					and M	-	_			0.7	100
			Registrar			Cer	tificate (	of D	eath				20	12	27	132
П	Physicia	ın/	1. Decedent's Name (First, Middle, La: Merle William Fis	,							2. Date of De August	ath 5 Day	y 201	<b>√e</b> ar	3. Time of 11:4(	
-4	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Tov	wn or l	Location o		August		. County of		11.40	J A ⋈
فرسه	LXdimii	CI	Broadmoor Assiste	*			1		rstov				Washi		on	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. la	ast birthday)	If Under 1	Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birthpl	lace (State or	r Foreign
	Director		190-12-5465 Usual Residence of Decedent	<b>™</b> M 2 □ F		87 yrs.		,,-			Aug. 19		24 I		sy1van	ia
	and show	ō	10a. State 10b. County		10c. City	, Town or Lo	ation				10	10d. Inside City Limits				
	Maryl 28a-f otifie	irec		ington		Hagers	stown								1 🔀 Yes	2 🗆 No
	th the 3a or t be n	a D	10e. Street and Number				10f. Zip Co		′ 0			_	izen of Wh		-	
	ath wi	<b>Funeral Director</b>	1175 Professional 11. Marital Status	12. Was Decedent E	ver in IIS	13 V		2174		nin? (Sne	cify Yes or No-		nited			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy right or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 XX Widowed 4 Divorced	Armed Forces?  1  Yes 2  If Yes, Give Year or Dates.		H	Yes, specify  Yes 2	Cuban	, Mexican	, Puerto	Rican, etc.)			White, et	tc.	
15-(	72 hou n "nati edica	Completed	15. Decedent's E (Specify only highest gr			(Give k	e kind of work done during most of working						ind of Busi	ness/Ind	ustry	
72	vithin in items.  In than the M	Con	Elementary/Secondary (0-12)	College (1-4 or 5	+)		o <i>NOT use rei</i> state I	,	ker/A	ppra	iser	Re	eal E	stat	.e	
pu	filed valued Hyg	Be	17. Father's Name (First, Middle, Last)								e (First, Middle,		-			
ylaı	Ment Ment Marked	To	Dean Martin Fisher						Grac	e Id	la Lamb:	ing				
, Mar	ealth and mm 27 is mm		19a. Informant's Name/Relationship (T Martin Fisher / So		- G						Route Numbe ddletov				ode)	
Baltimore,	. Page 1 a Iment of H tant: If ite jury or oth		20a. Method of Disposition  1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Contents)		CE	lace of Disposemetery, cremetery, cremetery	natory or other	r place,		ugus	oate 1 7 , 1 1 2		cation - Ci leric	-	<sub>vn, State</sub> a <b>ryla</b> r	nd
Ball	permit Depart Impor any in		21. Signature of British Service Licens	see		R 9	Name and A esthav 501 Ca	<sup>ddress</sup> en toc	Funei Funei tin N	al S Sount	Service tain Hw	s, S y. F	kkot reder	Cody	7 P.A. MD 2	1701
	Ph sician/		23a. Part 1. Inter the disease, or com shock or heart allure. List only o Immediate Cause Final	ne cause on each line.	100	Do not ente			, such as o	cardiac o	r respiratory arı	est,			Approximate Interval Betw Onset and D	veen
	Medical Examiner		disease r con Yon resulting in dealn)	a. Due to (or as a	consequ	ence of):		,								
	3165	ner	Sequentially list conditions, if they, leading to immediate cause. Enter Underlying													
	nd ransit	Examiner	Cause (Disease or injury that initiated events	c	qu!	al l	- ; px (	4 0	o, Ja	n						
	cate be executed physician and s the burial-transit	alE	resulting in death) Last	Due to (or as a		,	t a									
760	cate b physi s the t	edical		d	) ~ ~	Men	11 0		_							
.89	death certific	M/ne	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Cata = i = = = = =						23d. Date o	of deliver	у	j
O. Box	requires that the death certific been signed by the attending p should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at	time of de		Other (special						Month	1 [	Day Ye	ear
ds, P.(	The law requires that the ate has been signed by the page 2 should be detach	ρ	Part II. Other significant conditions of	ontributing to death bu	it not resu	ulting in the ur	nderlying caus	se give	n in Part I.						cause of deably 4 $\square$ U	
Records,	sician: The law rec certificate has bee lirector, page 2 sho	Completed									24a. Was autop	sy med?	pric dea	or to com ath?	sy findings av	vailable luse of
Vital F	ian: T irtifica ctor, p		25. Was case referred to medical examiner?				2	6. Plac	e of Death	n (Check	1 Yes	2 No	1 1 2	Yes 2	. L No	
$\geq$	Physic this ce al dire	မ	1 Yes 2 No			R/Outpatient		Other:	4 ∐ Nur		me 5 🗆 Resid	,		Specify)	15555	ted
o uo	ending Feath.	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		Year)	28b. Time of injury	I	Injury a work? 1 🔲 Ye	at es 2⊡i	- 1	8d. Describe h	ow injury	occurred		hiv	ing
Division of			3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injur building, etc.	y - At hor (Specify)	ne, farm, stre	et, factory, off	fice		2	28f. Location (S City or Tow		Number o	r Rural R	loute Numbe	<i>≥r</i> ;
	the Hospi nin 24 hou the Funer npletely fil	Medical	(Check 2 L. Medical Exami	sician: To the best of ner: On the basis of ex- se Practitioner: To the	amination	and/or investi	gation, in my c	poinion.	death occ	curred at	the time, date a	nd place.	and due to	the caus	se(s) and man	ner stated.
	Voiti Con		29b. Signature and title of certifier	M			29c. Lic		o 3 9	6		29d. Date	e signed (N	10nth, Da	ıy, Year)	
	3		30. Name and address of person who c	completed cause of de	ath (Item	23a) (Type, Pr	int) ()	26		45	Jimh	~	0	213	140	
4	Stat Registra	- I	31. Date filed (Month, Day, Year) AUG 0 9 2	012 32. Registrar		A. A	arked		J		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-06086 State of Maryland / Department of Health and Mental Hygiene Thomas Terrell Fisher 2012 27133 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day August 14, 2012 0909 hrs Thomas Terrell

4a. Facility Name (if not institution, give street and number) **Medical Examiner** 4c County of Death 4b. City, Town, or Location of Death Centreville Queen Anne's 220 Little Kidwell Avenue Apartment 1 If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Hours Months Days Director 1 7 M 2 F 196 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 Yes 2 No or 28a-f show entreville death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11, Marital Status 12. Was Decedent Ever in U.S Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 1 No Yes Black Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or injury or other transactic event, the Medical Examiner in injury or other transactic event, the Medical Examiner. If Yes, Give Year or Dates: 1 Yes 2 No specify: 4 Divorced Specify: 3 Widowed <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be homas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ittle Kidwell entre Ville, atricia 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, 20a. Method of Disposition 1 | Burial 2 Cremation 3 Removal from State 31 arnichael 4 Donation 5 Other Specify 22. Name and Address of Facility
Henry Funeral 21. Signature of Funeral Service Licensee HOME, P. Henry Funeral Home, H. H. Sio washington St. Cambridge, 23a. Pater. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear? Approximate Interval **Physician** Between Onset and /Medical Death aHypertensive Heart Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death certificate be executed Physician/Medical AMENDED23a,27,g930 8-27-12 sm attending physician for use as the burial -**X** UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown ģ Completed 24a, Was an 24b. Were autopsy findings available After this certificate has been prior to completion of cause of autopsy death? performed 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 Other: Scene 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending the Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

the Hospital or Attending Physician: within 24 hours at To the Funeral L

> Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

August 15, 2012

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13/M Mary Louise Franklin 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Hours 500-22-0062 Director 1 🗆 M 2 🗶 F March 30,1925 Missouri 87 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2X No Maryland Washington Hagerstown 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11023 Lincoln Ave. 21740 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc Completed by 1 Never Married 2 Married 2 X No Maryland 21215-0036 Yes 1 ☐ Yes 2x No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Home Daycare 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Maitland Greene Amy Lea Gowin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau Patricia E. Huffman - Daughter 6015 Potomac Drive Sharpsburg, Maryland 21782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation Hagerstown Crematory 08-16-2012 Hagerstown, Maryland 4 Donation 5 Other (S 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Securitially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 month for Day Pregnant at time of death signed by the a 1 Yes 2 4 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? After this certificate has autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes မ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 27. Manner of Death Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) death. Investigation 1 Yes 2 No within 24 hours after death

To the Funeral Director: /
completely filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie D060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal WAUSHED

State Registrar FARID

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	ate of Marylan	d / Depa	rtment of H	lealth and l	Mental Hyg	giene 21	112	27135	
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	uncate of L	eaur	2. Date of Dea		J 1 La,		
	Physicia Medic		Norma Estelle Fallens	stein				August		Year	3. Time of Death 8:58 A M	
	Examin		4a. Facility Name (if not institution, give street a Northampton Manor Nu:			4b. City, Town, or Frederi		1	4c. County	of Death	ick	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)		If Under 24 Hrs.	8. Date of Birth	1		ace (State or Foreign	
	Director		208-14-9721 1□M 2	2⊠	Yrs.	Months Days	Hours Min.	July 18,		Count	sylvania	
	and show d at	tor	Usual Residence of Decedent  10a. State  10b. County	10c. City	y, Town or Loc	ation				10	Od. Inside City Limits	
	Mary 28a-f otifie	Director	Maryland Frederick		Fred	erick					1 🔀 Yes 2 🗌 No	
	vith the 23a or st be n	ralD	10e. Street and Number 6512 Daytona Court,	Unit D		10f. Zip Code 21703	3		_	g. Citizen of What Country?		
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S med Forces?		/as Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No- Rican, etc.)		ce - America		
036	s after ral", or Exami	Completed by	If	☐ Yes 2 🛣 No Yes, Give ar or Dates.	1	☐ Yes 2X No	Specify:			Whit		
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ore,	ge 1 an t of He If item or othe		20a. Method of Disposition 1 ☐ Burial 2   Cremation 3 ☐ Remo	/al from State Co	emetery, crem	sition (Name of atory or other place	e) A119	Date 6	20c. Location	-		
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9	ate be ohysici the bu		d							-		
687	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If	yes, outcome of pregnal	ncy				23d, Da	ate of delive	rv	
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	1 Ves 2 Vo	☐ Live Birth 2 ☐ Feta ☐ Pregnant at time of d ☐ Unknown		Other (specify)	у		M	onth	Day Year	
<u>о</u> .	that th ned by e detac	y Ph	Part II. Other significant conditions contribut	ing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?	
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<u>=</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical			26. Pla	ace of Death (Che	1  Yes	2/ No	1 Yes	2 ∐ No	
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Division of Vital Records,	r Atten er deat rector: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At ho building, etc. (Specify,				28f. Location (Si		er or Rural	Route Number,	
á	pital or		29a. Certifier 1 Certifying Physician:			an unual of the time	data and place			nor as state	, d	
	ne Hosi in 24 hc ne Fune pletely	Medical	(Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Practice	the basis of examination	n and/or invest	gation, in my opinio	n, death occurred	at the time, date ar	nd place, and du	ie to the cau	se(s) and manner stated.	
	Vith To th		29b. Signature and title of certifier			29c. License	6499	-	29d. Date signe		ay, Year)	
	7		30. Name and address of person who complet	ed cause of death (Item	1 23a) (Tyne. P		/		F/1 6/1		50,00	
	3		Ronald E. Miller, M.	D. /4 Cull	well D	rive, Mou	ınt Airy,	MD 2177	71			
	Sta Registra		31. Date filed (Month Page Year) 7 2012	32. Registrar's Signat	ture A	and						

AMEND 29C & 29D PER MD G930 8/24/12 TRT State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Geyer Helen Pauline 8:42 A 07 5 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Golden Living Retirement Center Hagerstown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛣 F 87 08 26 1924 Morgantown, WV Director 234-32-3253 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 X Yes 2 □ No Hagerstown, MD Director MD Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 US 750 Dual Highway Funeral 12. Was Decedent Ever in U.S. Amed Forces?

1 ☐ Yes 2 ☒No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: if item 27 is marked other then 'ury or other traumatic avent, its Maury or other traumatic avent, its Ma Elementary/Secondary (0-12) College (1-4or 5+) clothing mfg. 12 seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edna Arthelia Austin LeRoy Paul Anderson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Greencastle, PA 17225 430 Catherine St. Diane B. Kittell Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Quincy Cemetery July 28,2012 Quincy, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Ind. 23a. Part | Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Domenus End Stores Waynesboro,

a. Domenus End Stores Waynesboro, 17268 Waynesboro, PA Approximate Interval Between Onset and Death Physician Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the ettending physicien and dbe detached for use as the burial-transit resulting in death) Last Due to (or as a conseque.... Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 Yes 21 No 1 ☐ Yes 2 ☐ No of Vital et or Attending Physicien: 1 s after death. st Director; After this certificat ad in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DO 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0045031 AUGUST 21, 2012 30. Name and ad person who comple a cause of death (Item 23a) (Type, Print) tectam Soci-87 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1 Decedent's Name (First Middle | ast) 2. Date of Death Day 2012 Month Physician/ Guiles 10:40 p.m. Eileen August Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Hospital Leonardtown Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Days Min. Hours **Director** 049-66-4563 1 □ M 2 🛚 F 11/10/1960 Connecticut 51 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral or items 23a 43000 Megan Lane United States 20650 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales 12 Salesperson Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Joan Patricia McSally Harold Stewart Guiles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or Att. 43000 Megan Lane, Leonardtown, MD Harold S. Guiles/Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🛚 Cremation 3 🗀 Removal from State Brinsfield-Echols Cre 08/17/2012 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brinsfield Funeral Home, P.A.
Toppardtown, MD 20650 Signature of Funeral Service Licenses

Friward N. Brinstield. MAKORAE 22955 Hollywood Road, Leonardtown, MD M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Heart Congestive disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events physician ar resulting in death) Last Physician/Medical obstructive pulmonary disea as signed by the attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform rmed2 2 No 2 🗌 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 🗸 Inpatient 2 🗆 ER/Outpatient 3 DOA မ 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD D68923 2012 We 30. Name and address of person who dempleted cause of death (Item 23a) (Type, Print) 25500 Point Lookout Road, Leonardtown, MD Guduri, M.D.<u>Vijaya L</u> Registrar's Signat State

DHMH 17 Rev 06-2011

Registrar

Sail Orec

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death Reg. No 2. Date of Death Decedent's Name (First Middle Last) 3. Time of Death August 5 Physician/ 2012<sup>Year</sup> 5:35 a <sup>M</sup> James Martin Glacken Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton 14 Crouch Chapel Rd. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Days Min. (Month, Day, Year) 212-60-6954 60 1 XM 2 □ F Director 4/12/1952 MD Usual Residence of Decede or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location be notified at Director 1 Tyes 2 XNo E1kton MD Cecil 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 27 is marked other than "natural", or items 23: traumatic event, the Medical Examiner must 21921 USA 14 Crouch Chapel Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【★No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Cook/ Chef Restaurant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Theresa Lorraine Wilson John Francis Glacken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 14 Crouch Chapel Rd. Elkton, MD 21921 Donna R. Glacken/ Wife or other item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 8/9/12° permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State R.T. Foard Funeral Home, P.A. Rising Sun, MD 4 Donation 5 Other (Specify) 22 Name and Address of Facility R. T. Foard Funeral Home, P.A. 259 E. Main St. Elkton, MD 21921 21. Signature of Funeral Service L art 1. Enter the ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ease, or complicat shock, or hear failt Immediate Cause (Final disease or comittion failure. List only one Interval Between Onset and Death Neoblasm of Physician/ Medical resulting in death) Due to (or as a consequence on Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last and -trar Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) Unknown the P.O. by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Division of Vital Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autonsv page 2 perform death? 1 🗌 Yes 2 🔀 No 1 Tes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other. 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at 28d, Describe how injury occurred Director: After (Month, Day, Year) 1 Natural 5 Pending 1 Tes 2 No within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0062190 12 10 SHAHNAWAZ KHAN MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUGUSTINE HERMANHWY, SUITEA, CHESAPEAKE CITY, MD 21915 32. Registra s Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ Henry P Grant 4:07 2012 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Charlotte Hall <u>Charlotte Hall</u> Veterans Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 04/07/1927 Months Days Hours Min. 1 X M 2 🗆 F Director 85 Pennsylvania 579-24-9485 Usual Residence of Decedent show 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Charlotte Hall Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20622 29449 Charlotte Hall Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Ş 1 X Never Married 2 Married 1X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29449 Charlotte Hall Road, Charlotte Hall, MD 20622 Angel Shifflett / Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD Brinsfield-Echols Cre 8/15/12 22. Name and Address of Facility Brinsfield-Echols Funeral Home P. 21. Signature of Funeral Service Licensee M00052 30195 Three Notch Road, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Universitying Cause (Disease or iinjury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the l 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 1 L Yes 2 L 9 Unknown a I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DISURDER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed To the Hospital or Attending Physician: The law require within 24 hours after death. To the Funeral Director After this certificate has been si completed filled in by the funeral director, page 2 should D15648E 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗆 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print)

Registrar

3altimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

20622

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12:15 PM Medical NG 4a. Facility Name (if not institution, give street and number) 4b. or Cation of Death Examiner 4c. County of Death, Medial TUS 3 OWN Birthplace (State or Foreign Country) War If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days 329-36-5929 Director 1 X M 2 🗆 F 68 Feb. 11,1944 Illinois 28a-f shov 10a. State 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Hagerstown Md. Washington 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21740 U.S.A14625 Daley Rd. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married X Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗆 No Specify "natural" Specify. 3 X Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Heating&Air Condition *Owner & Operator* Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Battersby Kurt Goshinsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Richard Goshinsky (Son) 14625 Daley Rd. Hagerstown,Md. 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Aug. Date 16 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2012  $Smithsburg_{ullet}Md_{ullet}$ permit. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Eradbury Ave. MOI414 Davis Funeral Home  $J \cdot L_{\bullet}$ Smithsburg.Md or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Meto Physician/ SMOLL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ctopic pregnancy
Other (specify) in the past 12 months? for Month Day Year 4 Pregnant a 9 Unknown Pregnant at time of death Yes 2 No detached Unknown ģ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform 1 Yes Yes funeral director, Be Was case referred to medical 26. Place of Death (Check only one) examiner? မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28a 28c. Injury at 28d. Describe how injury occurred injury work? 5 Pending Accident Investigation after death Suicide 6 
Could not be in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certific 0 29c. License number 29d. Date signed (Month, Day, Year) 8

State Registr<u>ar</u> 31. Date filed (Month, Day, Year) AUG 2 4 2012 MOSTUS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bettiejean GROUT 11°, 201°2 12:07p M August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 20014 Rosebank Way Washington Hagerstown 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept. 14, 2012 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. Funeral g. Birthplace (State or Foreign Hours 1 M 2 K F 90 215-18-2035 Director Pennsylvania Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director the Medical Examiner must be notified Maryland Washington Hagerstown 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20014 Rosebank Way 21740 U.S.A. Page 1 and 2 should be filed within 72 hours after death ν πent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married 2X No 1 Yes If Yes, Give altimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify: 3 Midowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 sales clerk retail sales Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William A. Fahrney Nora E. Wagaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheryl J. Smith - daughter 3403 Irish Hill Road, Magnolia, Delaware 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of h Important: If ite any injury or ot 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory August 2012 Hagerstown, Maryland 21. Signature of Juneral Service Licen 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused shock, or leart failure. List only one cause on each line Immediate Cause (Final ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition 61 Due to (or as a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or linjury burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a g Unknown q | | I Inknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 s certificate has autopsy death? Yes 2 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

TW-2

To the within 2

State Registrar only one)

29b. Signature and title of certifier

M % necle

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) 13

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Anne Arundel Mandrin Inpatient Care Center Harwood 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Days Hours Director 304-36-1188 1 2 M 2 D F 77 Yrs. 8/8/1934 Indiana Usual Residence of Decedent i Hygiene. other then "neturel", or Items 23e or 28a-f show vent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Millersville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21108 783 Brushwood Ct. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Defense Contractor Logistics permit. Page 1 end 2 should be filed w Department of Health and Mental Hygi Importent: If Item 27 Is marked othe eny Injury or other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Rozella Engledow Paul Groover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 783 Brushwood Ct., Millersville, MD 21108 Gloria Groover / Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/2012 Edgewater, MD Kalas Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. P. 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and ck, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CANCER ROSTATE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physiclen end I for use es the burlal-transli Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the sahould be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES Records, 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No **Division of Vital** To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) MANDRIN 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 14774 MID 7-31-12 445 DEFENSE Huy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17.0 SHA1410 4212

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day Year) 1 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month Year Ronald D. Hixon рΜ 3:45 2012Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 30 Boyd Drive Cecil Colora 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 13,1935 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ₹ M 2 □ F Months Days Hours Country) Minnesota 468-32-0745 **Director** 77 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Medical Examiner must be notified 1 Yes 2 X No Colora Maryland Cecil ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 30 Boyd Drive 21917 U.S.A. "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ρ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) the Petty Officer United States Navy One Year Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Harlan Hixon Viola Solseth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Cynthia H. Clark (daughter) 2091 Hopewell Road, Port Deposit, Maryland 21904 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West. Chester, permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) R.A.Ferris & Co., Inc. 08/06/12 <u>Pennsylvania</u> 21. Signal re of Funeral Service Licen Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ancer Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ک funeral director, page 2 should be Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 😾 No Division of Vital Be 26. Place of Death (Check only one) Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Investigation 2 🗌 No Accident 24 hours after deat Funeral Director: completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) D0044260

State Registrar HOSPITALIT

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32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KINZINGER

AUG 07

31. Date filed (Month, Day, Year)

12-06107 Gabrielle Held

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gabrielle Held State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 14, 2012 1658 hrs **Medical Examiner** Gabrielle Held 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Sykesville 6655 Sykesville Road 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Director 212-21-2657 Country) Korea 1 M 2 X F 32 10/5/1979 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location MD Carroll Sykesville 1 Yes 2 No items 23a or 28a-f show Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Heath and Mental Hygiene.
Impurtant: If item 27 is marked other than "natural", or items 23a or 28a-f sho
iujury nother traumatic event, the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6655 Sykesville Road 21784 USA Funera 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married 2 x No Yes Specify:Asian 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unemployed n/a 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Howard Maurice Held <u>Yolanda Garfield</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 19a. Informant's Name/Relationship (Type, Print) Yolanda Garfield, Mother 176 S. Andrews st. <u>Lake</u> Orion, MT 48 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Carroll Cremation 8/16/2012 Hamsptead, MD Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home M00741 Hampstead, Main St. Semmer Physician /Medical 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line Death aCardiac Arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and . transit Hospital ur Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical AMENDED 23a, pt.II, 27, per me, g932 10-17-12 sm ed by the attending physician a detached for use as the burial -X UNPENDED Box 68760, 23c. If yes, outcome of pregnancy IF FFMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>8</u> 1 Yes 2 No 3 Probably 4 Unknown Schizophrenia Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) 8 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 Yes 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) within 24 hours a determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 15, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Pay, Year) 2012 32. Registrar's Signature State ank Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death July ື2012 Physician/ 6:25 p Nancy Katherine Hollinger 31 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sykesville Carroll Fairhaven Retirement Village Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth Funeral Months Min (Month, Day, Year) 219-20-2202 107 Director 1 M 2 X F July 16,1905 Kentucky Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Maryland Sykesville 1 Yes 2 No Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r Funeral 21784 7200 3rd Avenue Carroll items Page 1 and 2 should be filed within 72 hours after death Was Deceus. Armed Forces? Ves 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian. "natural", or iten Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates white Specify 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working é. ∡than", life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Automobile Dealer Director 12 event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 27 is marked or traumatic even Sarah Martha Dickson ည Dexter Hamon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1000 Weller Circle #228, Westminster, MD 21158 Byron Hollinger, son Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemet South) or other place) 20c. Location - City or Town, State Date ☐ Burial 2 Cremation 3 ☐ Removal from State 8/2/2012 Winfield, MD Carroll Crematory 4 Donation 5 Other (Specify) Myers-Durboraw Funeral Home Signature of Funeral Service Licensee 22. Name and Address of Facility istar 91 Willis Street, Westminster, MD 21157 33a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one causa on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ 4 (HAFTON disease or condition Medical resulting in death) Due o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has page 2 certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after death Funeral Director: in by the 6 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F the only one) 29b. Signature and ti of certifie 29d. Date signed (Month, Day, Year) 29c. License number 9 8 Dorgor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month

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16 32. Registrar's Signature ROAD

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			FOT	partment of Health and M	lental Hygie		27116
			Registrar	ertificate of Death		g. No. 2012	
	Physicia		1. Decedent's Name (First, Middle, Last)  DEBORAH HURLEY		2. Date of Death	Day Year <b>901</b>	3. Time of Death  02:27 A M
1	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			UNIVERSITY OF MARKLAND MEDICAL CONTER	BALTIMORE			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 220-64-1377 1 \( \text{ M 2   XF} \) 56 yrs	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Cour	place (State or Foreign ntry)
	Director		220-64-1377   1 □ M 2 XF   56 yrs. Usual Residence of Decedent		02/02/19	56 Mar	yland
	land f shov d at	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	28a-i	Director	MD Frederick Frede				1 Tes 2 X No
	ith the		10e. Street and Number 6827 Larkspur Square	10f. Zip Code 21703		g. Citizen of What Cou <b>United Sta</b> t	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F		14. Race - Americ	
9	ter de , or it	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	If Yes, specify Cuban, Mexican, Puerto F  1  Yes 2 X No Specify:	Rican, etc.)	Black, White,	etc.
003	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	ted	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates.			Specify: Wh:	ite
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pu	e filed within 72 hours after death with the Maryland tral Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		iden Surname)	
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mo	Page nent o ant: If ury or		1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State scemetery, creditors, and state state state state state state state states.	ematory or other place) Crematory 8/9/2	012 F	rederick,	MD
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.			22. Name and Address of Facility <b>Stau</b> 104 E. Main St., Th			s, P.A.
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er				Approximate
er in .	Physician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition DECOMPENSATED AL	COHOLIC CIRRHOSIS			Interval Between Onset and Death
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Division of Vital Records, P.O.	requires that the der been signed by the s should be detached		Part II. Other significant conditions contributing to death but not resulting in the HEPATOLELULAR CARCINOMA	underlying cause given in Part I.		cco use contribute to t	
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Ζ	hysici his ce al direc	10 E	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpati		ne 5 🗌 Residend	ce 6 Other (Specifi	y)
ιof	ling Pr. After ti funera	ate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending  28a. Date of injury (Month, Day, Year) injury	work?	8d. Describe how	injury occurred	
siol	Attenc r death ctor: ,	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined determined	M 1 ☐ Yes 2 ☐ No treet, factory, office 2	28f. Location (Stree	et and Number or Rura	d Route Number.
Divi	tal or / s after al Dire ed in t		4 - Horniciae aeterminea building, etc. (Specify)		City or Town, S		
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred at t	the time, date and	place, and due to the ca	ause(s) and manner stated.
	To the within To the Comp.		29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	Day, Year)
			I Clean no	P27202		08/06/20	012
	, \		30. Name and address of person who completed cause of death (Item 23a) (Type,		1201		
	Stat	· A	ELHAM AFSHAR 22 S GREENE ST  31. Date filed (Month Day Year) 9 20 2 32. Begistrar's Signature		1201		
	Registra	ar	31. Date filed (Month Day Year) 9 2012 32. Registrar's Signature)	W CARE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2012 Vernard Roscoe Harden August 1:13 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min. (Month, Day, Year) 1 M 2 D F **Director** 230-50-2037 71 Yrs 09/ 13/ 1940 Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 Yes 2 No Maryland St. Mary's Dameron 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral with 1 United States 20628 17233 Three Notch Road items death v 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? "natural", or in edical Examine Black, White, etc. 1 Never Married 2 Married by and 2 should be filed within 72 hours after Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Black Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) ath and Mental Hygiene.

27 is marked other than er traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 5+ Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leech Sedonia John Otis Harden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17233 Three Notch Road, Dameron, Maryland 20628 permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other troonce. <u>Jacqueline A, Ha</u>rden-Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/17/2012 Peters Claver Saint Inigoes, Maryland 21. Sum Funeral ervice Michele Br 22. Name and Address of Facility Brinsfield Funeral Home Brinsfield Z山 22955 Hollywood Road, Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Prostake disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last attending physician and for use as the burial-train Due to (or as a consequence of): Be Completed by Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe ( Protein 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law autopsy performed? Yes 2 No certificate has 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital မ 1 🗌 Yes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No After ! 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident
Suicide Investigation within 24 hours after deatl 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

7)eme

Registrar DHMH 17 Rev 06-2011

State

Look

Name and address of person who completed cause of death (Item 23a) (Type, Print) 5500

Leck

AUG 1

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D69048

at Rd Learner town

			State of Maryland	/ Department of H			201	2 27148
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of L	Jean	2. Date of Deat	eg. No.	3. Time of Death
	Physicia		William A Howard Se			amust	Day Yes	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	MUNIT	4c. County of D	eath
	LXaiiiii	Č.	Anne Arundel Medical Cent	ter Anna	Dalis	9	Anne o	arunde/
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign
	Director		212-52-2880 XEXM 2□F 63	Yrs. Months Days		(Month, Day,		Country)
7	ow t		Usual Residence of Decedent  10a. State 10b. County 10c. City,	Town or Location		7 – –		10d. Inside City Limits
2	ied a	cto	Tod. State	TOWIT OF EGGATION				1 TxYes 2 No
<u>~</u> ≥	r 28a notif	Director	Maryland Anne Arundel Ann 10e. Street and Number	apolis 10f. Zip Code			l 0g. Citizen of What	
death with the Maryland	tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ra l						
the second	sma	Funeral	1421 Tyler Avenue  11. Marital Status  12. Was Decedent Ever in U.S.	2140		cifv Yes or No-	US 14 Bace - A	Merican Indian,
<b>O</b> 10	or ite	by F	Armed Forces?  1 ☐ Never Married 2 ☐ Married	13. Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, W	hite, etc.
	ral", Exar	ed t	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No	Specify:		Specify:	Black
nd 21215-0036	natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupa (Give kind of work done of	ation	na	16b. Kind of Busine	ess Industry
<b>17</b>	han e Me	E O	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired)	iding most of worki	'g		
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الالم	eveni	To Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		faiden Surname)	
Z a	and Mental is marked or aumatic eve		Charles E. Howard Sr.			Be1t		
Maryland 2 should be filed	h and Me 7 is mar traumati		19a. Informant's Name/Relationship (Type, Print) Sheila Howard (Wife)	19b. Mailing Address (Street at 1421 Tyler )				
	other traumatic			ce of Disposition (Name of			20c. Location - City	
	it of it		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cen	netery, crematory or other plac	e)		·	
altimore,	artme artme ortan injun		4 □ Donation 5 □ Other (Specify) Met  21. Signature of Funeral Service Licensee	ro Cremator			Baltimo:	
Balt	Department of H Important: If ite any injury or oth	-	Lavy S, Seese	22. Name and Addres Wm. Reese 11922 Fore	& Sons	Mortua Annapo	ry, P.A lis, Md	21401
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					Approximate Interval Between
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	Medical		resulting in death)  a.  Due to (or as a consequent	nce of):				11101111
E	xaminer		Sequentially list conditions, b.					
	+	Examiner	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying	iče Jīj.				4
executed	ind transi	хап	Cause (Disease or iinjury that initiated events				·	
be exe	cian a	alE	resulting in death) Last Due to (or as a consequen	ice oi).				
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Geath certifica	arten for us	ciar	in the past 12 months?	death 3 Ectopic pregnanc	ry .		23d. Date of Month	Day Year
ق ق	/ the	Physician/Me	1   Yes 2   No 4   Pregnant at time of dea 9   Unknown					
tat tat	ed by deta	by Pi	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause giv	ven in Part I.	23e. Did tol	pacco use contribute	e to the cause of death?
S, I	sign Id be					1 🗆 Y	es 2,⊠No 3 🗆	Probably 4 🗀 Unknown
law requires that the	shou	Completed				24a. Was a		autopsy findings available
VITAI KECOLOS, vsician: The law requires	e has	l li				autops perform	ned? death	to completion of cause of n? Yes 2  No
E E	tifical tor, p	Be C	25. Was case referred to medical	26. Pla	ace of Death (Check		ZANO	ies 2 🗆 NO
VIT.	is cer direct	To B	examiner? 1 ☐ Yes 2 ⋈ No  Hospital: 1 ⋈ Inpatient 2 ☐ EF	R/Outpatient 3 DOA Other	er: 4  Nursing Ho	me 5 🗆 Reside	ence 6 Other (S)	pecify)
<u>o</u> ₽	ter th		9 4 4 5 1 1	8b. Time of 28c. Injury work		28d. Describe ho	w injury occurred	
on ign	or: Af he ful	fica	2 Accident Investigation		Yes 2 No			
<b>DIVISION</b> Tal or Attendir	rer de irecto	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office		28f. Location (St City or Towr		Rural Route Number,
בֿ <u>פֿ</u>	urs all		<u> </u>		E			
Hosp	within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowled (Check 2 Medical Examiner: On the basis of examination a	nd/or investigation, in my opinio	on, death occurred at	the time, date an	d place, and due to t	he cause(s) and manner stated.
the	ithin 2	ž	only one) 3 Certifying Nurse Practioner: To the best of my k 29b. Signature and title of certifier	nowledge, death occurred at the			cause(s) and manner 9d. Date signed (Mo	
ř	≥ <b>⊭</b> ŏ		1 1/1/ mh/nn	dIP Ar	200 88	2	auch of	10,2000
•			30, Name and address of person who completed pause of death Mem 2	3a) (Type, Print)	JOC 00	eakla	ngo V	ploula
	Tw.		445 Dofenso How A	magalis	mi	2140	01	
	Stat	te	31. Date filed (Month Day, Year) 2012 31. Registrar's Signate		1			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Day Physician/ Alice Louise Hoenicka 3 2012 3:39 August Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death **Examiner** Golden Living Center Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 X F 220-28-9833 79 04/23/1933 Director Pennsvlvania Usual Residence of Deceden 28a-f shov 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Allegany Cumberland 1 Y Yes 2 No 10f. Zip Code 10e, Street and Number ö 10g. Citizen of What Country? Funeral or items 23a 1510 E. Oldtown Road, Apt C 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Salesclerk Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Randolph Denver Zembower Iona Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen S. Matthews / Daughter 709 Glenmore Street, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cumberland Crematory 08/17/2012 1 Burial 2 X Cremation 3 Removal from State Cumberland, MD 4 Donation 5 Other (Specify) 21. Signatur 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Sel 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Soler the disease or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 6 Immediate Cause (Final der Physician/ Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) signed by the a ld be detached f 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 🗌 Yes 2. No 3 ☐ Probably 4 ☐ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform After this certificate funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2. NO ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Investigation Accident within 24 hours after deat

To the Funeral Director:
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medica 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Detrition Repeated the basis of examination and or investigation, many opinion, and place, and due to the cause(s) and manner as stated only one 29b. Signature and to 29d. Date signed (Month, Day, Year) D0033280 14 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD

State Registrar 31. Date fill AUG 11 4 2012

NRS

32. Registrar's signature

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ □2012 George Washington Howarth August 7 10:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Homewood Retirement Center Williamsport If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number . Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ 165-24-9884 Director Pennsylvania 84 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Washington Co. Hagerstown 1 Tyes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** within 72 hours after death with 21742 18931 Manchester Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: White If Yes. Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ship Yard Machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events. ൧ Robert William Howarth Caribelle Lockey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 18931 Manchester Drive, Hagerstown, MD 21742 Joseph C. Tischer / Step Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Oak Lawn Cemetery Aug. 14,2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee Eastern Blvd. N., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that aused the leath. Do n shock, or heart failure. List only one cause on each lininter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final ECA'S ETT Physician disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Que to (or as a nunsequence of) cause. Enter Underlying sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown P.O. signed by the 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No has Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗋 Yes 2 🗌 No Accident
Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Iona F. Huffman Augus t 20**12** 1:05 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Record Street Home Frederick Frederick . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) ec. 23, 1927 West Virginia Days Hours 463-38-2744 Director 1 M 2 TYF 84 Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Frederick Frederick 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 115 Record Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White Completed 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Clothing 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lillie Drake Benjamin Franklin Nichols 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Meadowhill Drive, Myersville, MD 21773 Ralph Huffman Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Ceerted आप्रेमिक प्रकृति Gardens 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Clendenin, WV 8/10/2012 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Reeney & Basford P.A. 106 E. Church Street, Funeral H Frederick Home ck. <u>Mar</u>yland 21701 MO1612 23a. Part 1. Enter the disease, o complications that caused the death. Do not en shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a concequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequent resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performe 1 Yes within 24 hours after death.

To the Funeral Diractor: After this certifice completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name who comple of death (Item 23a) (Type, Print) AubrieJ V 300 31. Date filed (Month, Day, You AUG 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 August 12:56A M PAUL CHARLES **HOFFMAN** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours Director 192-32-7671 1 🖾 M 2 🗆 F 02/10/1942 70 PA Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD 1 Yes 2 X No Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7994 Pleasant Oak Dr. 21793 USA item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) configuration manager electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Bernard Hoffman Doris Meadows 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Bernadette Santore/wife 7994 Pleasant Oak Dr., Walkersville, MD 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of I Important: If it any injury or of once. cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 08/06/2012 Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ 0 Cardi MInutes disease or condition Medical resulting in death) **Examiner** いしついん Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Directo for selection of one equande of and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the SS IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year signed by the a ☐ Pregnam. ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should been 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to performe Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D41619 2 2012 Lerner

Registrar

DHMH 17 Rev 06-2011

0,

State

31. Date filed (Month

Michael A. Lerner ,MD 63 Thomas Johnson Dr. Suite E, Frederick, MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07 HALL Year 756 PM achel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Annapolis CUH M Anne Arunde Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 1 🗆 M 2 🔀 Months Days **Director** 92 Tennessee 579-28-6629 19.1919 ugust. Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 813 Midship Court 21401 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Force Yes 2 X No 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 Ind Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Human Services Senior Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Barlett Jordan Lilie M. Philyaw 1 and 2 should to the strength and the strength item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Carle / Daughter 11327 Dixie Drive, King George, Virginia 22485 Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 8-4-2012 Brentwood, Maryland of Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Part 1. If ier the disease, ir complication of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, inheart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed and I-trans Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day signed by the a 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of cate has death? perform this certificate 1 Yes 2 No Yes 2 No ospital or Attending Physician: hours after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C completed filled Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d, Date signed (Month, Day, Year) D43371 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are begible? State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 1122 AM Robert L. Imes 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WMHS-Regional Medical Allegany umberlane 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 - F 70 216-40-3221 Pennsylvania March 06, 1942 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16509 Lashley Drive SW 21532-U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) President Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Imes Thelma Dicken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502-Gary Imes MD 25 Mt. View Lane LaVale 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Cumberland Maryland ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park August 18, 2012 21. Signature of Funeral Service Licer 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Dant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if ary, leading to immedia cause. Enter Underlying Due to (or as a nonsequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 Pregnant 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ♣ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA

Physician/ Medical Examiner

Physician/

Medical

10a. State

12

**Examiner** 

**Funeral** 

**Director** 

show

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ıral", or items 23a or Examiner must be

"natural"

marked other

Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event,

the Medical

Page 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

notified at

Director

Funeral

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Completed

Be

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Examine as the burial-tran and the attending physician Physician/Medical for use a signed by the at Id be detached for Completed by Be ဂ္

IF FEMALE:

P.O. Box 68760

Division of Vital Records,

requires that the death certificate be Hospital or Attending Physician: The law to 24 hours after death.
Funeral Director: After this certificate has to After this certificate has To the I within 2 To the F

LINE FUNETRI DIFFCTOR: After this certificate has been sicompletely filled in by the funeral director, page 2 should it Certificate: Medical

31. Date filed (Month, Day, Year) State AUG 1 4 2012 Registrar

27. Manner of Death

A Natural

Accident

Suicide

4 Homicide

29a. Certifier

(Check

only one

5 Pending

Investigation 6 Could not be

determined

29b. Signature and the of certifie

28a. Date of injury (Month, Day, Year)

work?
1 Yes 2 No

28c. Injury at

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month,

CumberLANd MD21503

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

City or Town, State)

iress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad HOCK RUMAR 1100 BROOK

32. Registrar's Signature

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30 Day 2012 Year Junty 10:20 p м Judith Irving Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Crownsville 556 Palisades Blvd 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 😾 F Hours Min. (Month, Day, Year) England 74 576-70-6615 Director 0/09/1937 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Crownsville 1 Yes 2 No Anne Arundel MD 10e. Street and Numbe 10f. Zip Code or 10g. Citizen of What Country? items 23a or ner must be n Funeral 21032 USA 556 Palisades Blvd 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceud. Armed Forces? 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: White 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. if item 27 is marked other than "natural", other traumatic event, the Medical Exar 3 Nidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important. If item 27 is marked t any injury or other traumations. Deakin ٥ Mary John Lye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 556 Palisades Blvd Crownsville, MD 21032 19a. Informant's Name/Relationship (Type, Print) Rose Colvin Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 08/02/2012 Crownsville,MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility 851 Annapolis Road Gambrills, MD 21054 Hardesty Funeral Home P.A. Dals 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** CARONIC OBSTRUCTUE DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the at d be detached for Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MTPERCHOLESTEROLEIMIA 1 Kes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? has After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{K}\) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 🗷 Natural work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

5

29a. Certifier

(Check

only one) 29b. Signature and title

3 🗆

ANDREW MOGLUNE MD

State Registrar

31. Date filed (Month, Day, Year, AUG 0 1 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2002 MEDICA PARKUM SUTE HEAD ANNAPOUS MO strar's Signature ach

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0067349

29d. Date signed (Month, Day, Year)

2017

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2ď 12 01:15 AM August Billye Jo Jackson Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci1 3873 Turkey Point Road North East If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛣 F Days Aug. 13, 1937 Hours Months Tennessee 74 Director 430-58-9266 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2XXNo Maryland North East Ceci1 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21901 United States 3873 Turkey Point Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black White etc. 1 Never Married 2 X Married þ Saltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 X No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other frames. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Real Estate Agent Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elsie Reiter Hezzie Bonham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3873 Turkey Point Road, North East, Maryland21901</u> Lewis R. Jackson, Jr./ Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date August 8, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal fr Mayerdale Crematory Newark, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility Crouch Funeral Home, P.A. The Co 27 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYUCAdin disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 10 NARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician a Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy use 23d. Date of delivery 23b. Was decedent pregnant atten in the past 12 months? for Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 X within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s death?
1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Hospital မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 🗌 Yes 2 🗌 No injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

State Registrar

2

only one)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

12 Registi

29c. License number

33510

1).2

29d. Date signed (Month, Day, Year)

19702

UGUST 7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Physician/ Day 12:05PM Betty Jeane Jenkins Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Frostburg Nursing & Rehab.Center Frostburg <u>Allegany</u> 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 ☐ M 2**X** F Mar 25", YT923 Maryland 89 Director <u> 216-14-1286</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State Director 1 X Yes 2 No Frostburg MD Allegany 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21532 22 Braddock Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give ρ 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Rhea (Robinette) Bolinger Lester Bolinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Michael Jenkins Braddock Rd., Frostburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State Frostburg Memorial Pk Aug 20, 2012 Frostburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses Hafer Frost Mansion Frostburg, MD 58 Frost Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final candiovasular disease Priysician/ Atherosclero tic Smenthy disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a surresquence ut; Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 - Residence 6 - Cther (Specify) 2X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27. Manner of Death Certificate: 1 Natural 5 Pending Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Nonweck Shi MO 100055325 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walsh Rd Cumberland MD 21502 925 Bishop WONSOCK SHIN

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CHESTER V. JEFFREY, JR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 235-50-2624 **Director** 1 X M 2 □ F 06/07/1934 West Virginia Usual Residence of Deceder 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No WV Mineral Fort Ashby 10e. Street and Number 10f. Zin Code ō 10g. Citizen of What Country? Funeral items 23a 26719 2 Sugar Maple Lane U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 57-59 þ 1 Never Married 2 Married "natural", or permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify. White 3 ₩ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Master Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester V. Jeffrey, Sr. Louise Savannah Deboard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Kitzmiller / Daughter HC 84, Box 50, Burlington, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory 08/04/2012 Cumberland, MD 22. Name and Address of Facility Upchurch Funeral Home, P.A. re of Funeral Service St., Cumberland, MD 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, ician enro MYOCAMOIAL INFARCTION disease or condition resulting in death) Medical Examiner 14)10 MYO PA-17+ 6 MOUTHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has b director, page 2 s perform Yes 2 2 🗆 No 1 Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 🔽 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? s after death.

I Director: After to in by the funeral 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I 29b. Signature and titl PHYSICIAN 150844

Registrar

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912 Seton Drive Cumberland, MI) 21502

on who completed cause of death (Item 23a) (Type, Print)

JOCE

31. Date file NGth (P3 Y2012

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LOVERIA JR.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 19, Day 2012 Year Physician/ Roman Andrew Kadlubowski 10:55 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospice Dove House Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Oct 25, Months Hours Mary Land 218-03-9498 92 1919 Director 1 🗙 M 2 🗆 F Yrs Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City. Town or Location notified at Director 28a-f Carroll Westminster 1 Tes 2 No Maryland 10e. Street and Number 10f. Zip Code ms 23a or r must be r ō 10g. Citizen of What Country? Funeral 21157 225 Frock Drive Apt 338 USA 1 and 2 should be filed within 72 hours after death in f Health and Mental Hygiene. item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Telephone Equipment Factory Worker Department of Heath and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Egnac Kadlubowski Mary Nowakowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Frock Drive Apt 338, Westminster, MD 21157 Vera Kadlubowski, wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faiths Crematory 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 7/20/2012 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis St, Westminster, MD 21157 93a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final teart Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner OYO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant Year Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown **eral Director:** After this certificate has been sit filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{ No} \) 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Spec Hospice 2 No ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29c. License number D 0 0 6 5 2 4 6 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NILAR U jashington westmunste nth, Day, Year)
JUL 2 0 2012

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012<sup>ea</sup> August 7, 12:50 РΜ Kientz Ernest Joseph Medical 4a. Eacility Name (if not institution, give street and number): Caring Well Assisted Living 2612 Bel Pre Road 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Silver Spring Social Security Number If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days Hours Min (Month, Day, Year) Director 579-26-6937 1 DXM 2 DF 28, 1925 DC permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28a-f show eny Injury or other traumatic event, the Maries Evanther round be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 KNo Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S.

\*med Forces? World

War II 20906 2612 Bel Pre Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Installer Repairman Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Joseph Kientz Albertina Lundgren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George L. Kientz / Brother 13900 North Gate Lane, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory August 8, Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a Part 1 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 10 Yr. Recurrent Cerebrovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physicien end for use es the bunal-t am Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day After this certificate has been signed by the signeral director, page 2 should be deteched 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2x No 1 ☐ Yes 2 🔀 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 10+1

State Registrar Mary Ellen Ritchie, MD 2901 Olney-Sandy Spring Road, Olney, MD 20832

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 09 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ Month Richard Smith Karst Manges 3 August 8:21 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 737 Maryland Avenue Allegany Cumberland Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Hours. (Month, Day, Year) 09/29/194 70 **Director** 170-30-2786 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Mineral Ridgeley 1 Yes 2 No 10e. Street and Number ems 23a or r must be r ō 10f. Zip Code 10g. Citizen of What Country? Funeral Route 46 26753 USA items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, ortant: If item 27 is marked other than "natural", or itei injury or other traumatic event, the Medical Examiner was becedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Vietnam
Year or Dates. Epa Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hyglene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machinist Manufacturing 18. Mother's Name (First, Middle, Maiden Sumane) May Be 17. Father's Name (First, Middle, Last) ည Bowers Frederick Karst August 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wilma J. Karst / Wife 737 Maryland Avenue, Cumberland, MD item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of P Important: If ite Date cemetery, crematory or other place) 1 Durial 2 Dremation 3 Removal from State Cumberland Crematory 08/04/2012 Cumberland, MD 4 Q Ronation 5 Other (Specify) permit. atus of Funer I San 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 the Hospital or Attending Physician: The law hin 24 hours after death.

the Funeral Director: After this certificate has be page 2 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of pers

AUG 0 6

2012

of death (Item 23a) (Type, Print)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2012

		1 - For State Registrar		of Mar	yland / D	epartmer Certifica	t of H	ealth a Death	nd M		Reg. No.	20	112	27162
Physicia	ın	1. Decedent's Name (First, Middle, Dorothy Mae								2. Date of De Month Augus	Day	20	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution,		ımber)		4b. City	Town, or	Location of	f Death	Augus			of Death	7:30 p. M
- Examin	er	Golden Living		,				ersto			1	Vash	ingt	on
Funeral			6. Sex	7. Age (	In yrs. last birth	nday) If Under	r 1 Year Days	If Under 2		8. Date of Bi (Month, D.	rth			place (State or Foreign ntry)
Director		217-16-2920	1 □ M 2 🖾 F	91	Y	rs.		110010		Feb. 2	7,192	21	Wes	t Virginia
and	}	Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Town	or Location								10d. Inside City Limits
Mary -1 ehc	ţ	Maryland Wash	ington		на	gersto	m							1X∑Yes 2□No
r 28a	Director	10e. Street and Number	ingcon		110	10f. Zi					10g. Citi	zen of \	What Cou	ntry?
23e c		130 Ray Street	:				21	.740			USA	A		
is efter death with the Marylan is efter death with the Marylan , or iteme 23e or 28e-f show taminer must be notified at	Funerai	11. Marital Status	12. Was Dec Armed F	orces?	er in U.S.	13. Was Dece if Yes, spe	dent of Hi	ispanic Orig in, Mexican,	in? (Spe , Puerto	cify Yes or N Rican, etc.)	0-		e - Ameri ck, White,	can Indian, etc.
rs effe	by Fi	1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	ed 1 □ Yes If Yes, G Year or E	2 ⊠ No ive		1 ☐ Yes	2 <b>⊠</b> No	Specify:				Specify	v: wł	nite
5 E-M		15. Decedent's	s Education		16a. I	Decedent's Usu	al Occupa	ation			16b. Kii	nd of B	usiness/In	idustry
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should be nd Mental marked c	၉	19a. Informant's Name/Relationsh			19h	Mailing Addres	c (Street					Tour	State Zi	n Codel
permit. Peges 1 end 2 should be filed within Inspertment of Heelih and Mental Hygiene. Important: if item 27 ie marked other then eny injury or other traumatic event, tra Monea.		Anna V. Barnhar		hter		32 Ray	•							·
them of the		20a. Method of Disposition			20b. Place of	Disposition (Na	me of			ate	1			own, State
Peges nent of I nnt: # lis		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State		Lawn Me			8/18	/12	Hage	rst	own,	Maryland
permit. Departr Importa		21. Signature of Funeral Service L	icense	7		22. Name a				INNICH				dente community (
1 40559		· con		les.	me							sto	wn, l	Md. 21740
Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a	ach line.		être c						an	20	Approximate Interval Between Onset and Death
be executed siclen and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	`	consequence o									
ficate be ex physiclen is the burial		Todaling in doubly Edd	d.	o (or as a c	consequence o	т):								
To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death certificate within 24 hours after death. After this certificate has been signed by the ettending phys completely filled in by the funeral director, page 2 should be detached for use as the law and the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 nant at tir	pregnancy Fetal death ne of death	3 □Ectopic p 5 □ Other (s		,	T. T. A				ite of delive	rery Day Year
w requires that the de been signed by the should be detached t	à	Part II. Other significant condition	1s contributing to	death but	not resulting in	the underlying	cause giv	en in Part I.			tobacco u		tribute to	the cause of death?
Physicien: The law re r this certificate has be rrai director, page 2 sho	Completed					_				24a. Wa auto peri 1 Yes	opsy formed?		Were autophor to condeath?	opsy findings available ompletion of cause of
iclen: sertific ector,	Be	25. Was case referred to medical examiner?	Manadani				. I au			(Check only				
Physical direction	၉	1 Yes 2 No  27. Manner of Death		Inpatient		patient 3 D		4 ( <u>-</u> 3.19u)		me 5 Res				fy)
After funer	tion	1 SNatural 5 ☐ Pending 2 ☐ Accident investig	, ,	of Injury nth, Day	(ear)	ine of ijury M	28c. Injur Wor	ya≀ k? Yes 2.⊟1	_ 1	280. Describe	now injur	y occur	Ted	
i or Attendati after death Director: d in by the	ertification:	3 Suicide 6 Could not determine	ot be 28e. Place	e of Injury ding, etc.	/ - At home, far (Specify)	m, street, facto				28f. Location City or To	(Street an own, State	d Numi	ber or Rur	ral Route Number,
To the Hospital or Attending I within 24 hours after death to the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1/1 Certifying (Check only one)	g Physician: To the examiner: On the and ma	ne best of basis of e	xamination and	, death occurred Vor investigatio	at the tir	ne, date and pinion, deat	d place, th occurr	and due to the	e cause(s) e, date and	and m	anner as and due	stated. to the cause(s)
To t To ti	Σ	29b. Signature and title of certifier  Menyar	g pro					e number	65					, Day, Year)
W-8		30. Name and address of person was a series o	DSH	API	th (Item 23a) (	Type, Print) WULL	Stv	cel-1	Hage	staru	ME	2	1740	)
Sta	te	31. Date filed (Month, Day, Year)	2019	egistrar'	s Signature	had								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ August 1<sup>2</sup>2<sup>y</sup>, 2012 10:25 P M Betty Marie Kirby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Retirement Center Williamsport If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days (Month, Day, Year) 219-07-0294 Director 1 □ M 2 XX 90 Jan. 1, 1922 Maryland or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director 1 X Yes 2 No Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Examiner must be 1 once. Funeral 21795 USA 154 North Artizan Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Yes 2XXNo by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: White If Yes, Give 3 XXWidowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Clerk/Cashier Pharmacy Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lewis McComas Garrish Meta B. Mentzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20014 Rosebank Way Philip G. Kirby, Sr. - Son Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XXBurial cemetery, crematory or other place) 2 Cremation 3 Removal from State 08-16-2012 Williamsport, Maryland Greenlawn Mem. Park 5 Other (Specific 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD Sign ure of Fineral Sen 425 S.Conococheague St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) use as the burial-transit that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month ρ onths? Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No this certificate has 1 Yes 2 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Hospital or Attending work?
1 Yes Natural 5 Pending 24 hours after death.
Funeral Director: Aft letely filled in by the ful 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifler 2

Registrar DHMH 17 Rev 06-2011 mo

Itagerstown

Northern

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5,80 C

Shahid Mahmood

31. Date filed (Month 1969eq) 5

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FEMALE:   230. Was decedent pregnant in the past 12 months?	oe exec cian a		resulting in death) Last	Due to (or as a co	nsequence of):						
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elhamy Eskander, MD 501 W 7th Street Frederick, MD 21701	icate by physical phy		1 225000	d							
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elhamy Eskander, MD 501 W 7th Street Frederick, MD 21701	ending r use	an/N	23b. Was decedent pregnant	23c. If yes, outcome of p	regnancy Fetal death	3 ☐ Ectopic pregnanc	ev.		23d. D	ate of delivery	,
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elhamy Eskander, MD 501 W 7th Street Frederick, MD 21701	al or A		4 Homicide determined			street, factory, office				ber or Rural Ro	oute Number,
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  Elhamy Eskander, MD 501 W 7th Street Frederick, MD 21701	Hospit 24 hour Funera etely fille	edica	Check 2 ∟ Medical Exami	<b>ner:</b> On the basis of exami	ination and/or in	vestigation, in my opinio	n, death occurred at	the time, date an	nd place, and d	ue to the cause	e(s) and manner stated.
Elhamy Eskander, MD 501 W 7th Street trederick, MD 21701	To the within To the comple	Σ		e Practitioner: To the be	st of my knowled						
Elhamy Eskander, MD 501 W 7th Street trederick, MD 21701			1/1			D	4818	4	8/	6/10	2
Od Date filed Aldrew Day Vood	8		31	/		! ! !	7th sto	est FC	ederic	KM	N 21701
Begistrar Alla U (2012 Senson & Darker						how del	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			<u> </u>	021.

			State of Maryland / De	partment of Health and ertificate of Death		65
			Registrar  1. Decedent's Name (First, Middle, Last)	erillicate of Death		
	Physicia Medic		Mary Ethel Long		2. Date of Death Judy 26 Pay 2012ear 3. Time of Death 5:35	М
	Examin		4a. Facility Name (if not institution, give street and number) 5775 Bowers Road	4b. City, Town, or Location of Dea	4c. County of Death  Carroll	
	Funeral Director		5. Social Security Number 219-14-7892  6. Sex 1 □ M 2 ► 7. Age (In yrs. last birthda	Months Days Hours Mil		ign
70	t ow	L	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limit	ito
arvlan	a-fsh fieda	ecto			1 $\square$ Yes 2 $ note 1$	
the M	or 28 e noti	Öİ	MD   Carroll   Taney	10f. Zip Code	10g. Citizen of What Country?	$\dashv$
h with	ns 23a nust b	nera	5775 Bowers Road	21787	USA	
after deatl	Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	<ol> <li>Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue</li> <li>Yes 2 No Specify:</li> </ol>	Specify Yes or No- orto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White	
2 hours after	"natur dical I	Completed	15. Decedent's Education 16a. De	cedent's Usual Occupation ve kind of work done during most of w	16b. Kind of Business Industry	┨
<b>17</b> I	ene. • than he Me	Com	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)	Own Home	
and A	other rent, t	Be	17. Father's Name (First, Middle, Last)		lame (First, Middle, Maiden Surname)	$\neg$
<u>a</u>	Menta larked atic e	욘	Maurice Orndorff	Ire	ne Wivell	
Mar 12 shou	alth and 27 is m r traum		f I		Rural Route Number, City or Town, State, Zip Code) Taneytown, MD 21787	
ore, eland	of Hei If item or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Discemetery, of the complete of Discementary, of the complete of Discementary, of the complete of t	sposition (Name of crematory or other place)	Date 20c. Location - City or Town, State	
Dalumore Dermit. Page 1 ar	rtment rtant: njury o		4 ☐ Donation 5 ☐ Other (Specify) St. Jose	eph Cath. Cem.	7/30/2012 Taneytown, MD	_
Derm	Depar Impo any ir once.		21. Signature of Funeral Service Licensee	136 E. Baltimo	yers-Durboraw F.H. re St. Taneytown, MD 2178	87
			23a. Part . Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			
	sician/	8 1	Immediate Cause (Final disease or condition resulting in death)		Onset and Death	
	Medical xaminer		Due to (or as a consequence of).			
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter undarying Cause (Disease or linjury			$\neg$
ecuted	and -transi	xam	Cause (Disease or linjury that initiated events resulting in death) Last C. Due to (or as a consequence of):			$\dashv$
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ertificate	ng phy as the	Medi	IF FEMALE:			
e death cer	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2  Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year	
Jo, P.O.	n signed by Ild be detac	þ	Part II. Other significant conditions contributing to death but not resulting in the dementia (1725	e underlying cause given In Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4 Unknow	wn
The law required	ate has bee oage 2 sho	Completed			24a. Was an autopsy autopsy prior to completion of cause of performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	
VILAII   ysician:	ertifica ector, p	Be	25. Was case referred to medical examiner? [Hospital:	26. Place of Death (Cl	neck only one)	
o Physi	r this o	6: 10	1 Yes 2 No 1 Inpatient 2 ER/Outpa 27. Manner of Death 28a, Date of injury 28b. Time	tient 3 □ DOA  4 □ Nursing e of 28c, Injury at	Home 5 Residence 6 Other (Specify)  28d, Describe how injury occurred	$\dashv$
or inding	ath. r: Afte ne fune	icat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation	y work? M 1 🗆 Yes 2 🗆 No	, ,	
DIVISION tal or Attendir	after de <b>Directo</b> in by tf	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
Hospital	24 hours a Funeral I eted filled	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, dea	th occured at the time, date and place vestigation, in my opinion, death occurred at the time, date and	, and due to the cause(s) and manner as stated.  d at the time, date and place, and due to the cause(s) and manner sta	tated.
To the	within <b>To th</b> e comp	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	$\neg$
	/		N. And Mal Mos	MD025270	7/27/12	
27	C/		(Check 2	e. Printy 14154 St Arendt	tsuille Pa 17303	
	Stat Registra		31. Date filed (Month, Day, Year)  JUL 2 7 2012  32. Fegistrar's Signature,	parke		

		Please	e Type or Pri						<del>-</del>		_	ble.		
	For State Registrar		State of M	arylanc		rtment of tificate of		and N		giene Reg. No	0.0	12	27	166
Physician/	1. Decedent's Nam	ne (First, Middle, La Cathryn Le							2. Date of De. July	ath 10	20	Yegr	3. Time of 8:50	
Medical Examiner	4a. Facility Name (i	if not institution, giv	ve street and number) n Village			4b. City, Town,	or Location	of Death	Dury				ounty	
Funeral	5. Social Security N 216–10–	Number 6.	Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Year Months Day	r If Unde	r 24 Hrs. Min.	8. Date of Birl (Month, Da	 th		9. Birthp	lace (State o	or Foreign
Director	Usual Residence		1 □ M 2 🛛 F	96	Yrs. Town or Loc	ation			Aug. 2	6, 1	915	Mary	Land  Od. Inside Ci	ity Limite
Maryland 28a-f sh otified a	Maryland	Carroll	County		stead	ation						<u>'</u>		2 <b>K</b> No
leath with the Maryland Items 23a or 28a-f sho Item must be notified at Funeral Director	10e. Street and Nu 4216 Hi	ımber 11crest 2	Avenue			10f. Zip Code 21074					tizen of W Ced S			
by min	11. Marital Status  1  Never Mar  3  Widowed	rried 2 □ Married 4 □ Divorced	12. Was Decedent   Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates.		If	/as Decedent of Yes, specify Cu	ban, Mexica	an, Puerto	ecify Yes or No- Rican, etc.)			- Americ k, White, e whi	etc.	
ithin 72 hours aftene. r than "natural" the Medical Exa		15. Decedent's ecify only highest of	grade completed)		(Give k	ent's Usual Occ ind of work don NOT use retire	e durina mo	st of work	ing		(ind of Bu			
Hygiene. Other tha ent, the N	Elementary/Sec		College (1-4 or s	5+)	bookk	NOT use retire		h l - N l	e (First, Middle,		uckir		.rm	
id be file Mental H arked of	17. Father's Name Harry I								Lizabeth					
d 2 shou alth and 27 is m er traum		lame/Relationship Sue Kenr	(Type, Print) nedy / niec	æ		g Address (Stre Old Mar								7
age 1 and ent of Her it: If item y or othe			Removal from State	ce	metery, crem	sition (Name of atory or other p		July	<sup>Dat</sup> 20, 2012		ocation -	-	wn, State Maryla	and
permit. Po Departme Importar any injur once.	21. Signature of Fo		nsøe	101072	22	Name and Add	ress of Faci	lity <b>E</b>	line Fur	nera	1 Hor	ne		
	23a. Part 1. Enter shock, or he	the disease, or co art failure. List only	mplications that caused one cause on each line	d the death.	Do not ente	r the mode of d	ying, such a	s cardiac	or respiratory ar				Approximat Interval Bet	te tween
Physician/ Medical	Immediate Cause disease or conditi resulting in death)	ion	a. Meta.  Due to (or as		ence of):	reast	Can	ncel	2				Onset and I	Death
Examiner	Sequentially list c	onditions,	b. Due to (or as	Dev a conseque	nen]	1a_								
executed an and rial-transit	cause. Enter Undo Cause (Disease of that initiated even resulting in death)	erlying r injury nts	c. Due to (or as	LM6 a conseque	nary ence of):	ARTE	RY	0158	ase					
= ± a 6			d	PN	21100	5 C	VA							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certificate: To Be Completed by Physician/Medical Exami	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 9 Unknow	2 months?	23c. If yes, outcome 1  Live Birth 4  Pregnant a	2 Fetal	death 3	Ectopic pregna Other (specify)					23d. Dat Mor	e of delive	-	Year
gned by to detact			contributing to death t	but not resu	Iting in the u	nderlying cause	given in Par	t I.					ne cause of d	
The law requires cate has been signage 2 should the Completed	-								1	an	24b. V	Vere auto	oably 4   osy findings	available
sician: The law r certificate has b lirector, page 2 s									auto perfo 1 🗆 Yes	ormed?		eath?	mpletion of a	ause of
Physician: T r this certifica eral director, p: To Be C	25. Was case referexaminer?	rred to medical No	Hospital:	ient 2 🗆 E	ER/Outpatien		Place of De other:		k only one) ome 5 Resi	dence_	6 🗌 Othe	r (Specify	)	Part.
ath.: After this e funeral o	27. Manner of Dea 1 Natural 2 Accident	ath 5  Pending Investigati	28a. Date of inju (Month, Da		28b. Time of injury		jury at ork? □ Yes 2[	□No	28d. Describe I	how inju	ry occurre	d		
or Attending P after death. Director: After to in by the funers Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of Inj	jury - At hon c. (Specify)	ne, farm, stre	et, factory, offic	е		28f. Location ( City or Tox			r or Rural	Route Numb	ber,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certificate		2 Medical Exa	nysician: To the best of miner: On the basis of e	examination	and/or invest	igation, in my op	inion, death	occurred a	it the time, date	and place	e, and due	to the car	use(s) and ma	anner stated.
To the within 7 To the comple	only one) 29b. Signature and		urse Practitioner: To th	ne best of my	y knowledge,		at the time, o	ate and pi	ace, and due to		ate signed			
25C	30. Name and add	dress of person wh	Completed cause of a	death (Item :	23a) (Type, P	rint) ,	1/1-	14	4 . 4	-07	[ /	201	4	
5 State	OR, 2 31. Date filed (Mon	E, Wald	2012 32. Popistr	o 57,	LUK8	rint)	le,	West	minste	e,	Md.	2	1/58	
Registrar		JUL 10	2014		1. 14									

		_	For	State of Ma	aryland				Mental Hy	giene	
			State Registrar			Cer	tificate of L	Death		Reg. No. 20	2 27 167
Н	Physicia	n/	1. Decedent's Name (First, Middle, Last)				. N. C. C.		Date of Dea     Month	Day Ye	3. Time of Death
~~	Medic	al	4a Facility Name (if not institution give of		RUTH	L LA	ANTZ	- Landing of Dec	Augus		
)	Examin	er	4a. Facility Name (if not institution, give st Frederick Memo		enit	ا د	4b. City, Town, or	r Location of Dea erick	atn	4c. County of E	derick
	Funeral		5. Social Security Number 6. Sex			st birthday)	If Under 1 Year	If Under 24 Hi		h g.	Birthplace (State or Foreign
	Director			М 2 [ХГ	96	Yrs.	Months Days	Hours Mi	Dec. 10	, Year 1915 M	lary land
	now at	ايا	Usual Residence of Decedent  10a, State  10b, County		10c City	, Town or Lo	cation				10d. Inside City Limits
	arylar a-f sk fied a	Director	MD Frederick	:		rederi					1 X Yes 2 □ No
	the M or 28 e noti		10e. Street and Number				10f, Zip Code			10g. Citizen of What	
	with s 23a ust b	Funeral	252 Dill Avenue				2170	1		United St	ates
	death item: ner m			2. Was Decedent E	ver in U.S	. 13. V	Vas Decedent of H	ispanic Origin? ( an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		American Indian, Vhite, etc.
36	after I", or xamir	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Yes 2 H	No		☐ Yes 2 🎗 No		,	Specify: W	
8	is filed within 72 hours after death with the Maryland tal Hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Edu	Year or Dates.		16a. Deced	lent's Usual Occup	ation		16b. Kind of Busine	
215	n 72 h an "n Medi	m	(Specify only highest grad	e completed) College (1-4 or 5	+)	(Give I life. D	kind of work done ( O NOT use retired)	during most of w	orking		
2	l withi ygiene her th t, the		Elementary/Secondary (0-12)			Nurse	9			Nursing	
nd	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) Wade W. Warrenfelt	7					ame (First, Middle, E. DeLaut	,	
Maryland 21215-0036	2 should be file th and Mental I 27 is marked o traumatic eve	_	19a. Informant's Name/Relationship (Typ			401-14-15	A.I. (7)				7to Ondal
Ma	2 shoulth and 27 is m		Robert Twentey	(Sor	1)	1	-			r, City or Town, State 1kersvi 11	e, MD 21793
re,	1 and of Hea item other		20a. Method of Disposition	•	20b. Pl	ace of Dispo	sition (Name of		Date	20c. Location - City	
m 0	Page nent c int: If		1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Mou	nt Oli	natory or other place. vet Cem.	8/2	20/2012	Frederick	, Maryland
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service Licensee			22 10	Name and Addre			eral Home ick, MD 2	
ш	<u>~</u> 0 = 0	Ш	Physic Duge	*	612	1	06 E'. Ch	urch St	., Freder	ick, MD"2	1701
П			23a. Part 1. Inter the disease, or complishock, or heart failure. List only one Immediate Cause (Final	cause on each line							Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	Due to (or as a	NA	PRY	HKI	EKY	DISE	HSE	Once and Board
	Examiner			Due to (or as a	Conseque	ence on.					
		iner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):					
10	ite be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events								
3	e exec cian a ourial-	al E	resulting in death) Last	Due to (or as a	a conseque	ence of):					
092	physic physic the b	edical	d	l							
89	eath certifica attending pl	N/	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome						23d. Date of	f delivery
Box 687	leath e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant a  9 ☐ Unknown			Ectopic pregnand Other (specify)	СУ		Month	Day Year
P.O. E	hat the dea ed by the a detached f	Physician/Me	g Unknown			della da di c					
σ.	Attending Physician: The law requires that the death certificate be executed at death.  **T death.** ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	by	Part II. Other significant conditions con	tributing to death b	ut not rest	ining in the u	ndenying cause gr	ven in Part I.			e to the cause of death?
rds	requir peen s should	etec									e autopsy findings available
9	The law ate has b page 2 s	Completed								rmed? prior deat	to completion of cause of h?
of Vital Records,	i <b>ician:</b> The certificate rector, pa <u>c</u>		25. Was case referred to medical				26 PI	ace of Death (C)	1 Ves	2 No 1 □	Yes 2 No
Vita	ysician: is certific director,	To Be	examiner? 1 \( \sum \) Yes 2 \( \sum \) No	ospital:	ent 2 🗆 i	ER/Outpatier	t 3 DOA Oth	er.		lence 6 Other (S	pecify)
of	ng Ph fter th ineral	1 3	27. Manner of Death  1 ■ Natural 5 □ Pending	28a. Date of injui	y ; Year)	28b. Time of injury	28c. Injur work		28d. Describe h	ow injury occurred	
ion	Attending P death. ctor: After to y the funers	ifica	2 Accident Investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 No			
Division	or At after of Direct	Certificate:	4 Homicide determined	28e. Place of Injubulding, etc			eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral d	Medical	29a. Certifier 1 Certifying Physic	ian: To the best of	my knowle	edge, death o	occurred at the time	e, date and place	e, and due to the ca	use(s) and manner a	s stated.
	he Ho lin 24 he Fu ipletel	Med	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse	er: On the basis of ex Practitioner: To the	camination best of m	and/or invest y knowledge,	igation, in my opinio death occurred at t	on, death occurre the time, date and	d at the time, date a d place, and due to t	nd place, and due to the cause(s) and mann	the cause(s) and manner stated. er as stated.
	Noith Noith		29b. Signature and title of cartifier		1 ^		29c. License			29d. Date signed (Me	onth, Day, Year)
			1/1/		10		1/0	0614	10	HUGI, 1	1, 2012
	10		30. Name and address of person who co	mpleted cause of de		23a) (Type, P	TO CC	- Hou	SE . /	FREDE	17, 2012 RICK, MD
À	Stat	te 🦠	31. Date filed (Month, Day, Year) AUG 2 4 2012	32. Registra		Jre	·				
	Registra	ar	AUG 2 4 2012 Der	una > B.	ba	Mad					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012

		-	1 - State Of Maryland / Depart	ificate of Death	Reg		27100
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Murray Leroy Lighty		2. Date of Death	) <sup>2</sup> <sup>y</sup> /201 <sup>y</sup> 2 <sup>r</sup>	3. Time of Death 10:00а м
adding.	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
الإسماد	Funeral		7515 Belle Ridge Ct  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Hughesville  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	g. Birthp	olace (State or Foreign
	Director		230-44-4828 1X M 2 D F / 5 Yrs.	Months Days Hours Min.	(Month, Day, Ye) 01/22/1		ginia
	show d at	to	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Local MD.		1	0d. Inside City Limits	
	e Mary r 28a-f notifie	Director	MD Charles Hughesv	111e	1100	. Citizen of What Cour	1 Yes 2 No
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral		20637		nited Sta	•
	r death or item iner m			as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	etc.
9036	urs afte ural", c Il Exarr	ted by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates.	Yes 2 <b>X</b> No Specify:		Specify: Bla	.ck
215-(	า 72 hol a <b>n "nat</b> Medica	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	nt's Usual Occupation nd of work done during most of worki NOT use retired)	ng	b. Kind of Business/Ind	_
1212	d within 72 lygiene. ther than ' nt, the Me	Be Co		ping & Receivi		Pharmaceu	tical
land	l be filed lental Hy rked oth tic event	면 면	17. Father's Name (First, Middle, Last) Matthew Lighty	18. Mother's Nam Mattie	e (First, Middle, Maio Richard	den Surname) dson	
Mary	should h and Me 7 is mar raumati		quagnett	Address (Street and Number or Rura			
re,	1 and 2 of Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposi	Belle Ridge C		c. Location - City or To	
Baltimore, Maryland 21215-0036	riit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.		4 Donation 5 Other (Specify) Chesape			eltsville	•
Bal	permit. Page 1 ar Department of He Important: If iter any injury or oth		21. Signature of Funeral Service Licensee 22. Wanda C. Balon CC0361 34	Name and Address of Facility $W ullet F$	H. Bacon WW Washi	Funeral ngton,DC	Home 20010
		П	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	eg - 4.c	lung		Onset and Death
	Examiner	يا					
	pg _ 2_	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Diter fundrying Cause (Disease or injury				
	ificate be executed g physicial and as the burial tr	al Exe	that initiated events resulting in death) Last    C.    Due to (or as a consequence of):				
292	icate be physic ts the b	ledical	d				
89	cert ndir use	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1	Ectopic pregnancy		23d. Date of delive	ery Day Year
Box	de de	Physician/N	1   Yes 2   No 9   Unknown	Other (specify)		Mona	Day Icai
, P.O.	The law requires that the death rate has been signed by the attepage 2 should be detached for	by	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		co use contribute to the	
ords	require been s should	leted			24a. Was an	24b. Were autor	osy findings available
Rec	The law ate has page 2	Completed			autopsy performed 1 Yes 2	d? death?	mpletion of cause of 2  No
ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: Inpatient 2 ER/Outpatient	26. Place of Death (Check		<u>                                     </u>	
of V	ng Phy fter this ineral d	ite: To	27. Mapner of Death 1 Natural 5 Pending (Month, Day, Year) 28. Date of injury (Month, Day, Year) 28. Time of injury		28d. Describe how i	e 6 Other (Specify injury occurred	)
Division of Vital Records,	Attendi death. ctor: A by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree	at and Number or Rural	Route Number,
DIV	ital or / irs after al Dire		building, etc. (Specify)		City or Town, S		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifical completely filled in by the funeral director,	Medical	29a. Certifier  1. Certifying Physician: To the best of my knowledge, death oc (Check only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, only one)	gation, in my opinion, death occurred at	t the time, date and p	lace, and due to the car	use(s) and manner stated.
		<	29b. Signature and title of certifier	29c. License number		. Date signed (Month, I	
U	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr	IN KRISHAN M.	MATHUR	M.D.	1)
			2505 Davis Road	negldont	WY		20
	Sta Registr		31. Date filed (Month, Day, Year) AUG 0 9 2012  32. Registrar's Signature	1.			

		3; nls, per Plea , Allegany Co.	se Type or Pr State of M						-		gible.	
		1 - State Registrar 1. Decedent's Name (First, Middle,				rtificate c				Reg. No. 2	012	27169
Physici Med	ical	Kathryn L. Lohr							Month	July 27, 20	17-	012. Time of Death AM 06:36 PM M
Exami	Н	4a. Facility Name (if not institution, Frostburg Nursing &	Rehab Center			4b. City, Tow	Fros	tburg		Alleg		
Funera Director		5. Social Security Number  218-60-1581  Usual Residence of Decedent	6. Sex 1 □ M 2 🂢 F	ge (In yrs. Ia 91	ast birthday) Yrs.	If Under 1 Your Months Da	ays Hours	der 24 Hrs. s Min.	8. Date of Bir (Month, Da Augus	th ay, Yea <i>r)</i> <b>it 21, 1920</b>	Cot	hplace (State or Foreign untry) ryland
Maryland 28a-f show otified at	Director	10a. State 10b. County			y, Town or Lo	cation						10d. Inside City Limits 1   Yes 2 □ No
th the Ma 3a or 28s	al Dire	10a Street and Number	gany Mechanic Street	-	stburg	10f. Zip Coo				10g. Citizen o	f What Co	111111111111111111111111111111111111111
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	/ Funeral	Apt. 11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Vas Decedent f Yes, specify C		Origin? (Spec	cify Yes or No- Rican, etc.)	U.S.A.	ace - Amer	rican Indian,
Maryland 21215-0036 2 should be filed within 72 hours after tht and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exami	eted by	1 Never Married 2 Marri 3 Widowed 4 Divorced	1  Yes 2  If Yes, Give Year or Dates.	No		1 ☐ Yes 2 🔀		ify:		Speci	fy: Wh	nite
1215- thin 72 ho sne. than "na the Medio	Completed	(Specify only highes		5+)	(Give life, D	dent's Usual Ockind of work do O NOT use reti	ne during m	ost of workir	ng	16b. Kind of		Industry
and 2 e filed wi ntal Hygie ed other event, til	To Be	12 17. Father's Name (First, Middle, La	ast)		Home	emaker			,	Maiden Surna		
Tarylashould band Me is mark		Arthur Lancaster  19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mailir	ng Address (Str			eora Sipp Route Numbe	er, City or Town,	State, Zip	Code)
re, N l and 2 l Health ltem 27 other tr		Doris Rader 20a. Method of Disposition	Niece	20b. P	lace of Dispo	Winchester	f	1	berland ate	Mai 20c. Location	ryland	21502-
Baltimore, permit. Page 1 and Department of Hee Important: If item any injury or othe		1 M Burial 2 Cremation 4 Donation 5 Other (Sp	pecify)	,	rostburg	matory or other Memorial I	Park	Jul	y 31, 2012	Frostbu		Maryland
Ba perm Depa Impo any i		21. Signature of Funeral Service Li	censee		22	. Name and Ad <b>Durst Fu</b>		-	rost Ave.	, Frostbur	g, MD	21532
Physician/ Medical Examiner		23a. Part 1. Enter the disease, or of shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	complications that cause his one cause on each line.  a	e. Eden	oHic	Candle of		0	,			Approximate Interval Between Onset and Death
60 the be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b									
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	Ideath 3	Ectopic pregr Other (specify					Date of deli	v <b>ery</b> Day Year
rds, P.O. equires that the sen signed by to ould be detach	þ	Part II. Other significant condition	ns contributing to death b	out not resu	ulting in the u	nderlying cause	e given in Pa	ırt I.				the cause of death?
Division of Vital Records, all or Attending Physician: The law requires s after death.  I Director: After this certificate has been signed in by the funeral director, page 2 should by	Completed								24a. Was autor perfo 1 \(\sum \) Yes	osy ormed?	prior to c death?	opsy findings available ompletion of cause of
Vita ysiciar ysiciar is certii	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ient 2 🗆 I	ER/Outpatien	1	Out -	eath (Check		dence 6 🗆 Ot	her (Specia	60
n of ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending	28a. Date of inju (Month, Da	iry	28b. Time of injury	28c. Ir	njury at vork?	28		now injury occu		
Divisio tal or Atten rs after deat al Director ed in by the	al Certificate:	2 ☐ Accident Investiga 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ot be	ury - At hor c. (Specify)	me, farm, stre			-	8f. Location (S City or Tow		ber or Rura	al Route Number,
the Hospi nin 24 hou the Funer	Medical	only one) 3 Certifying I	Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	examination	and/or invest	igation, in my or	pinion, death	occurred at t	he time, date a	ind place, and d	ue to the ca	ause(s) and manner stated
To To To COOM		29b. Signature and title of certifier	kshin	MI	2	29c. Lice	ense number	325		e cause(s) and r 29d. Date sign July	ed (Month,	
MAI		30. Name and address of person w	ho completed cause of d	leath (Item	23a) (Type, P Valsh K	rint).	nberl	und	MD:	2-1502		
Sta Registr	te ar	31. Date filed (Month, Day Year)	2 32. Registra	ar's Signatu	ire sark	1						

			State of Marylar				d Mental Hy	giene	0 07170
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	tificate of I	Death	T	Reg. No.	2 2/1/0
Н	Physicia		KATHLEEN T. LANDERS				2. Date of De Month 07	30 2012	3. Time of Death
M	Medi Examir		4a. Facility Name (if not institution, give street and number)		4b. City, Town, o	or Location of De		4c. County of I	
-			108 N. Smallwood Street		Cumbe			Alleg	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi			. Birthplace (State or Foreign Country)
	Director		217-30-2052 Usual Residence of Decedent	Yrs.			08/31/		est Virginia
	show show	ě		ty, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-f otifie	Director	MD Allegany (	Cumber1	and				1 🏋 Yes 2 □ No
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	alD	10e. Street and Number		10f. Zip Code	0		10g. Citizen of Wha	t Country?
	nth wil ms 2; must	Funeral	108 N. Smallwood Street	a Lieu	2150			U.S.A.	
(0	er dez or ite niner	y Fu	11. Marital Status  12. Was Decedent Ever in U. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married		Was Decedent of H f Yes, specify Cuba	dispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, Vhite, etc.
93	rs aftu ıral", Exar	ed b	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	1	∣ ☐ Yes 2 ∏ No	Specify:		Specify:	White
5-0	2 hou "natu edica	Completed by	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occup		vorkina	16b. Kind of Busin	ess/Industry
121	thin 7 ane. than	Com	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Di	ÖNOT use retired) memaker	odinig moot or vi	roming	Home	
9	filed within al Hygiene. d other tha	Be (	17. Father's Name (First, Middle, Last)	110	memaker	18 Mother's N	Name (First, Middle,		
ılan	ild be fil Mental narked o	မ	Robert A. Davis				aret Gilm		
Maryland 21215-0036	and and is n		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or I	Rural Route Numbe	r, City or Town, State	e, Zip Code)
2	and 2 s Health tem 27		Timothy Landers /Son			ourt, Ne	ew Market	, MD 217	74
Jore	ge 1 and the state of the state		1 Burial 2 Cremation 3 Removal from State	cemetery, cren	sition (Name of natory or other plac		Date / CO. 1	20c. Location - Cit	-
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		4 Donation 5 Other (Specify) SS.		& Paul				lnad, MD
Ba	Deparential Depare		Mondon texchere	)  "	202 Gre	ene St.	pchurch F , Cumber1	uneral HO	me, P.A. 21502
г			23a. Part 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line.	th. Do not ente					Approximate Interval Between
	Physici_n		Immediate Cause (Final disease or condition	JUE .	M	ELO	MA		Onset and Death
2	Medical Examiner		resulting in death)  Due to (or as a conseq	uence of):					
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseq	uence of):					
	uted d ansit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events  c						1
	exectian and and and and and and and and and a	J Ex	resulting in death) Last Due to (or as a conseq	uence of):				. =	
9	ate be executed ohysician and the burial-transit	dical	d						
687	requires that the death certifics been signed by the attending p should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnant 23c. If yes, outcome of pregnant	ancv					
ŏ	eath c atten	iciar	in the past 12 months?  1 Live Birth 2 Fet 1 Ves 2 No 4 Pregnant at time of	al death 3 🗌	Ectopic pregnand Other (specify)	СУ		23d. Date of Month	f delivery Day Year
P.O. Box	the diby the	hys	9 ☐ Unknown						
<u>~</u>	s that gned be de	by F	Part II. Other significant conditions contributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
rds	een si ould	ted					_ 1 🗆	Yes 2 No 3	Probably 4 Unknown
000	law r has b je 2 sl	Completed by					24a. Was autor	osy prior	e autopsy findings available to completion of cause of
Ä	n: The ficate or, pag		25. Was case referred to medical					rmed? deat	Yes 2 No
/ita	rsicial s certi	To Be	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 I	EB/Outpotion	Oth	ace of Death (Ch			
Division of Vital Records,	ding Physician: The law h. After this certificate has funeral director, page 2		27. Manner of Death 28a. Date of injury	28b. Time of injury	28c. Injun	y at		dence_6  Other (S) ow injury occurred	pecify)
lon	eath. or: Aft the fu	fica	1.  Natural 5  Pending (Month, Day, Year) 2  Accident Investigation 3  Suicide 6  Could not be	injury	M 1 🗆	Yes 2 No			
VIS	al or Attending P s after death. Il Director: After ti ed in by the funera	Certificate:	4 Homicide determined 28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
Ω	spital	ledical	29a. Certifier 1 Certifying Physician: To the best of my know	ledge, death o	ccurred at the time	e, date and place	and due to the ca	suse(s) and manner a	s stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	(Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of t	n and/or investi	gation, in my opinic	on, death occurre	d at the time, date a	nd place, and due to t	he cause(s) and manner stated
	To t		29b. Signature And title of certifier		29c. License	number	(0)	29d. Date signed (Mo	onth, Day, Year)
	10		Hi wo Vou	00-1/2	00	034	02	7(4	8115
	Sals		30. Name and address of person who completed cause of death (Item Alia Power M.D. ~/35	52 ///i	lowbra	ok Bd.	Cumbo	rknd. M	0 21502
	Stat	е	31. Date filed (North, Day Year) 12 32. Registrar's Signa	ture land	1		,1,		
	Registra	ir i	Comme p.	The war	Ti .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death Month Physician/ August 09:10 PM Gladys Druscilla Leatherman 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County 12906 Cathedral Ave. Hagerstown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex **Funeral** Age (In yrs. last birthday) (Month, Day ) Days Hours 1 □ M 2 💢 F Mary Land 213-68-6799 **Director** 101 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral U.S.A. 21742 12906 Cathedral Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Ida Florence Martin George Ellsworth LeFever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17527 Woodlawn Dr. Hagerstown, MD 21740 Luther K. Leatherman, Jr.-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery 8-15-2012 | Clear Spring, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home of Funeral Service License 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Immediate Cause (Final Operand Death Physician/ rear disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list nonditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 10 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5104 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 WNo Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ★Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C the Hospital Medical 29a. Certifier 1 🖅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 2012 02 Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Registrar

		1 For State	ate of Marylar				and Mental Hy	/giene		
		Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of	Death		Reg. No. 2	012	2717
Physicia		Joyce Ann Lawler					2. Date of De Month August		Year o	3. Time of Death
Medic Examir		4a. Facility Name (if not institution, give street a	nd number)		4b. City, Town, o	r Location o			2012	7:57 A M
		13003 Resh Road				gersto			y of Death <b>Washin</b>	aton
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days	If Under 2		th		ace (State or Foreign
		473−36−0122 1 □ M 2 Usual Residence of Decedent	XX⊧ 79	Yrs.	Wioritins Days	Hours	July I	1,1933	Can	ada
land shov	ţō	10a. State 10b. County	10c. Cit	ty, Town or Loc	ation				10	ld. Inside City Limits
Many 28a-1 otifie	Director	Maryland Washington	n		Hagerst	own			"	1 ☐ Yes 2XXNo
th the 3a or t be n	alD	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Countr	
ath w	Funeral	13003 Resh Rd.				21740			JSA	
ire, Maryland 21215-0036  1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by F	1 Never Married 2 X Married Am	s Decedent Ever in U.S ned Forces? Yes 2 X No es, Give ir or Dates.	If	/as Decedent of H Yes, specify Cuba	n, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)		ce - Americar	c.
5-0 Phour	olete	15. Decedent's Education		16a. Decede	ent's Usual Occup	ation			AATT	ite
2121 Within 72 Ygiene. Per than t, the Me	lmo:		lege (1-4 or 5+)	(Give ki life. DO	ind of work done of NOT use retired)	luring most o	of working	16b. Kind of B	usiness/Indu	istry
ed wil	Be C	17. Father's Name (First, Middle, Last)			Homema				Home	e
Maryland 2 should be filed v th and Mental Hyg 7 is marked othe traumatic event,	2	William Alexander St	t John				's Name <i>(First, Middl</i> e, <b>ora</b>	Maiden Sumam Paquet		
and N		19a. Informant's Name/Relationship (Type, Print	.)	19b Mailing	Address (Street a					
re, M l and 2 s r Health item 27 other tra		Robert J. Lawler, Sr 20a. Method of Disposition		13003	Resn Ro	. Hage	or Rural Route Number	aryland	21740 21740	
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		1 Donation 5 Other (Specify)	I from State		tion (Name of itory or other place Cremato	:	Date Ligust 15,2012	20c. Location -		
Bal permit Depar Impor any in		21. Signature of Funeral Service Liasnsee		22.	Name and Addres	s of Facility	Osborne	Funeral	. Home	, P.A.
	$\dashv$	23a Part 1 Enter the dispass of complications	4	42	5 S. Con	ocoche	eague St.Wi	lliamsp	ort, M	MD 21795
Physician/		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final					ardiac or respiratory arre	est,	In	pproximate Iterval Between
Medical	1	disease or condition resulting in death)	Pan cre	etic	Canc	er				nset and Death
Examiner			to (or do a confocque	5110 <del>0</del> 01).						
D it		cause. Enter Underlying	ue to (or as a conseque	ence of):					_	
ecute and Il-trans	-xal	Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a conseque							
cate be executed physician and sthe burial-transit	edical Examiner	Di	re to (or as a conseque	ence on:						
	- 1	d								
eath certifica attending pl		F FEMALE: 23b. Was decedent pregnant 23c. If yes	s, outcome of pregnand	cy				23d Date	of doliver	
the att	200	1 L Yes 2 No 4 L	Live Birth 2 Fetal Pregnant at time of de Unknown	ath 5 🗆 C	ctopic pregnancy other (specify)			Mon	e of delivery oth Day	y Year
that the dea		Part II. Other significant conditions contributing		ting in the cond						
signe Id be	-4	g	to death but not lesur	ung in the und	enying cause give	n in Part I.		acco use contril		
v require	nai bieren									y 4 <b>X</b> Unknown
The law ate has page 2	5						24a. Was ar autops perforn	y pr	ere autopsy frior to comple eath?	findings available etion of cause of
ysician: The		25. Was case referred to medical			26 Place	o of Death //			Yes 2	No
Physic this ce al dire	<u> </u>	examiner? 1 Yes No Hospital:	1 ☐ Inpatient 2 ☐ EF	R/Outpatient			ng Home 5 Reside	200 E	(0	
or Attending P after death. Director: After t in by the funer	2	7. Manner of Death 28a. [		8b. Time of injury	28c. Injury a work?		28d. Describe how			
Attence death core; ye the		2 Accident Investigation			M 1 Ne	s 2 No				
al or y		4 Homicide determined b	lace of Injury - At home uilding, etc. (Specify)	e, farm, street,	factory, office		28f. Location (Street) City or Town,	eet and Number State)	or Rural Rou	te Number,
To the Hospital or Attending Physician: The law requires that the death certification of the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a Medical Certificate. To Reformation the Director Law Completely filed in the funeral director page 2 should be detached for use a second certificate.	2	29a. Certifier Check Che	he best of my knowled	ge, death occi	urred at the time, o	late and place	ce, and due to the caus	sale) and manna	r on stated	
the H thin 24 the F mplet		only one) 3 Certifying Nurse Practition	basis of examination a oner: To the best of my	nd/or investigat knowledge, dea	ion, in my opinion, ath occurred at the	death occurr time, date ar	red at the time, date and old place, and due to the	place, and due to cause(s) and mai	o the cause(s)	) and manner stated.
No N	29	9b. Signature and title of certifier			29c. License na	umber	29	d. Date signed (	Month, Day,	Year)
	0.0	Name and address of	77		1000	6899	15	8/14	/201	2
W-6	30	O. Name and address of person who completed of Yong Tang, which is the second of the s	30 Opul	3a) (Type, Print)	ta Deasto	. מכתו	15 AAD 21	07/10		
State	31	. Date filed (Month, Day, Year)	2. Prigistrar's Signature		0			170		
Registrar		AUG 15 2012	A see A	pa	M.					
MH 17 Rev 06-201	1			- F						

12-05475 Jae Kap Lee

M M	Date of Death Month Day Year 1326 hrs  4c. County of Death Anne Arundel  Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	
4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death Anne Arundel	
8048 Telegraph Road I Severn		
		4
Marilla David Harry Mari	Mar. 27, 1941 Foreign Country) Korea	
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limit	ts
MD Anno Anundol Course	1 ☐ Yes ZXXX N	10
Anne Arundel Severn  10e. Street and Number 10f. Zip Code 8048 Telegraph Road 21144	10g. Citizen of What Country?  USA	
PROPOSE TO Sever 1 100. Street and Number 101. Zip Code 101. Was Decedent of Hispanic Origin? (Specify 11. Was Decedent of Hispanic Origin? (Specify 11. Yes, Specify Cuban, Mexican, Puerto Ricar 12. Yes, Sp	y Yes or No- 14. Race - American Indian, Black,	
11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 W No specify:	Specify: Asian	
15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired)		
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. Do NOT use retired)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. Do NOT use retired)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. Do NOT use retired)  17a. Father's Name (First, Middle, Last)  17b. Decedent's Usual Occupation (Give kind of work of during most of working life. Do NOT use retired)  16a. Decedent's Usual Occupation (Give kind of work of during most of working life. Do NOT use retired)  17a. Father's Name (First, Middle, Last)	Liquor Store	
Owner  17. Father's Name (First, Middle, Last)  Nyungkwan Lee  19a. Informant's Name/Relationship (Type, Print)  Jae Woo Seo - Cousin  2 Owner  18. Mother's Name (First Mangkum 19b)  19b. Mailing Address (Street and Number or Rural 19b)  Jae Woo Seo - Cousin  13835 Castle Blvd., Apt	st, Middle, Maiden Surname)	_
Mangkum  Nyungkwan Lee  Mangkum  19b. Mailing Address (Street and Number or Rural	Route Number, City or Town, State, Zip Code) 2090a	4
Jae Woo Seo - Cousin 13835 Castle Blvd., Apt  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date		^ 1
Jae Woo Seo - Cousin		
1. Signature of Funeral Service Densee	II Funeral Home	7
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or responses.		
Tailure. List only one cause on each line.    Immediate Cause (Final disease a. Asphyxia	Between Onset and Death	d
or condition resulting in death)  Due to (or as a consequence of):  Bequentially list conditions,		
if any, leading to immediate  Leause. Enter Underlying Cause  Due to (or as a consequence of):		
if any, leading to immediate cause. Enter Underlying Cause (Disease or Irigury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.	/	
d.  UNPENDED  AMENDED  AMENDED  AMENDED  AMENDED  AMENDED		
F FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year	- 51
Female:   Female:   Female:   Specify   Spec		
O the state of the	23e. Did tobacco use contribute to the cause of death?	
ted by P.C.	1 Yes 2 No 3 Probably 4 Unknown  24a. Was an 24b. Were autopsy findings available	_
Records, The law requires fricate has been sig page 2 should be Completed	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No	
26. Place of Death (Check only of examiner?	one)	=
examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Hor  1 Yes 2 No  28a. Date of Injury  28b. Time of Injury 28c. Injury at Work?  Sub	ome 5 Residence 6 Other Scene  1. Describe how injury occurred	_
The state of the s	pject hanged self	
28e. Place of Injury - At home, farm, street, factory, office building, etc.	Location (Street and Number or Rural Route Number, City or Town, State) 8 Telegraph Road, Severn, MD	ly
4 Homicide Single Family Home 29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the control of the c	to the cause(s) and manner as stated.	T
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.  29b. Signature and title of certifier	e time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)	
O.C.M.E.	July 27, 2012	
30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, March 2016 Assistant Medical Examiner 900 W. Baltimore 900 W.	MD 21223	
State Registrar  State Registrar		$\dashv$

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mark L. Miller 12:52P <sup>M</sup> 2012 Medical Ju1v 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospital 5. Social Security Number 6. Sex If Under 1 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 F Months Days Hours 2/9/1931 220-30-3461 Director Yrs 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "marshing or other transmit injury or other transmit. 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2XXNo MD Ceci1 North East 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 390 Old Elk Neck Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Completed Specify: 3 Widowed 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fork Lift Operator Auto Mfg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William McKinley Miller Pearl Rakes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Gray - daughter 2391 Turkey Point Rd. North East, MD 21901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Friends Cemetery 8/2/2012 Calvert, MD 21. Signature of Juneral Service Licen 22. Name and Address of Facility R.T. Foard Funeral Home, PA Oueen Street, Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death - Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine ath certilium.

le attending physician and

...e as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ed by the a detached f signed by be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown been 8 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy his certificate hil director, page performed' death? 2 🔀 No 2 X No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending 1 Natural work? 1 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director; / 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062190 MD 10 2

Registrar

State

HERMAN

30. Name and address of person who completed cause of death, (Item 23a) (Type, Print)

GUSTINE

Registra

33

SHAHNAWAZ

I SUITEA, CHESA

PEAKECITY, MD21915

			Plea	ase Type or	Print in	Black I	ndelible Inl	k. Ensi	ure A	II Copies	Are L	egible.			
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	-	Registrar  1. Decedent's Name	e (First, Middle	e (ast)		Ce	rtificate of L	eath		2. Date of Dea	Reg. No.		3. Time of D		
Physicia Medic		Kenneth		Mi11		August 4Day 2012						Рм			
Examin -	er	4a. Facility Name (if 961 Bigg		4b. City, Town, or Risi	Location o		4c. County of Death Cecil								
Funeral	1	5. Social Security N	umber	6. Sex	7. Age (In yrs.	If Under 1 Year Months Days	If Under		8. Date of Birth			thplace (State or I	Foreign		
Director		219-36-1 Usual Residence	1 🔀 M 2 🗆 F	M 2 □ F 72 Yrs.			Wighting Days Friedrick			40					
yland f shov ed at	tor	10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City		
r 28a- notifie	Funeral Director	MD 10e. Street and Nun	Cec	<u>i1</u>	R	ising	Sun 10f. Zip Code				100 Cition	n of What Co	1 🗆 Yes 2	2 🔀 No	
with th	eral	961 Bigg		Wav			2191	1			-	JSA	outti y r		
items	Fun	11. Marital Status	3 mign		dent Ever in U.	S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Orio	gin? (Spe	ecify Yes or No-		Race - Ame			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  The most and the most is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1  Never Marr 3  Widowed		ried 1 Yes	2 🔼 No e	1	1 ☐ Yes 2 🎛 No				Spi	Black, White ecify:	White		
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tal Hyg	To Be	17. Father's Name (	First, Middle, I	Last)						e (First, Middle, I	Maiden Sun	name)			
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2 sho		19a. Informant's Na		ler – wif	2		ng Address <i>(Str</i> eet a						o Code)		
1 and of Hea of item		20a. Method of Disp	osition		20b. l	Place of Dispo	osition (Name of matory or other place			Date		tion - City or	Town, State		
Page ment tant: It		4 Donation	5 Other (S		Wes		ingham Ce					ng Sun			
permit Depart Import any inj once,		21. Signature of Fur	neral Service I	icensee	0 -		2. Name and Addres						Home, F	PA	
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that th	by Ph	Part II. Other signif	ficant condition	ons contributing to d	eath but not res	sulting in the I	underlying cause giv	en in Part I		23e. Did to	bacco use	contribute to	the cause of dea	ath?	
quires en sign ould bo	ted t	Hypika	lemia				1 □ Yes 2 ₽ No					No 3 □ P	3 Probably 4 Unknown		
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/siciar s certif	To Be	examiner?	P No	Hospital:	Inpatient 2	ER/Outpatie	26. Place of Death (Check only one)  ont 3 □ DOA Other: 4 □ Nursing Home 5 ☑ Residence 6 □ Other (Specify)						ifu)		
ng Phy ter this ineral		27. Manner of Death	h 5 🗆 Pendir	28a. Date		28b. Time of injury	nt 3 🗆 DOA   4 🗀 Nursing Home 5 🖾 Residence 6 🗀 Other (Specity)								
ttendii death. tor: Ai / the fu	Certificate:	2 Accident 3 Suicide	Investi	gation not be	of Injury At b	ama farm at		Yes 2 🗌	$\rightarrow$	006			nal Oscida Alcinska		
al or A s after al Direc ed in by		4  Homicide	determ		ng, etc. (Specify		reet, factory, office			City or Town		umber or Hui	ral Route Number	,	
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check 2	Medical E	Physician: To the bear	is of examination	n and/or inves	stigation, in my opinio	n, death oc	curred at	the time, date an	nd place, an	d due to the	cause(s) and mann	ner stated.	
To the within To the compl-	Σ	only one) 3 29b. Signature and		Nurse Practitioner	To the best of	my knowleage	29c. License		e and pla		29d. Date s	igned Month	h, Day, Year)		
1		Jay	wh K.		r Okn			244:	37	3	8/	6/20	/Z		
		30. Name and ddd	ess of person	who completed caus		n 23a) (Type, I	Print)	Risi	na S	Sun. MI	) 210	11			
Stat		31. Date filed (Mont.	h, Day Year	07 2012	egistrar's Signa	iture	A WHY	10101	9	- MILLION	- 4-1	11		_	
Registra	ar 💮			- LOIL	1 Halles	1 1	Barke								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Ammended Box #3 Per Phys. WSH Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ John Jeffrey Marley-Cass 29 Tuly 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 8/28/1947 Days Hours Director 216-48-1037 1 🔀 M 2 🗆 F MD 64 and 2 should be filed within 72 hours efter death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Hampstead Carroll 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21074 4422 Black Rock Road, Apt 4 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 X Married 1 √2 Yes 2 ☐ No If Yes, Give 1968 Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Divorced 4 Divorced Completed Year or Dates 1970 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Transit College (1-4 or 5+) Elementary/Secondary (0-12) Carroll Area Transit driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thelma Marian Hines John Wesley Marley-Cass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210744422 Black Rock Road, Apt. 4, Hampstead, MD Barbara Marley-Cass, wife other 1 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carroll Cremation 7/31/2012 Hampstead, MD 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home Main St., Hampstead, MD 21074 934 S. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) Exam Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No the be detached g 🗌 Unknown g Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital 2 🗌 No မှ 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) . Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural Certificate: 28d. Describe how injury occurred 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month. Day, Year) WHIOTIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WESTMINSTER, MD

Registrar DHMH 17 Rev 06-2011

State

BEHARI, MO

31. Date filed (Month, Day, Year)

200

32. Registrar's Signature

MEMORIAL

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	State of Manyland / Department of Health and Mental Hygiene

Sean Patrick Ming	1	- For State Registrar	S	tate of N	Maryland		rtment o tificate o			d Men	tal Hy		eg. No	20		2 2717
Physician Medical Examine		1. Decedent's Name Sean Pat			r						2	2. Date of Dea Month August 7,	Day	Year		3. Time of Death 1739 hrs
		4a. Facility Name (i		r)	4b. City, Town, or Location of Death Fort Washington					August 1,	4	c. County of D				
Funeral	۱	1360 King C 5. Social Security N		errace 6. Sex	7. A	ge (In yrs. Ia	ıst birthdav)		Jnder 1 Yea		r 24Hrs.	8. Date of Bir		Prince Geo		S nplace (State or
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Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	- (1)	19a. Informant's Na		1 ( )1 /	,	۵	40		•			rai Route Nun			state,	Zip Code)
re, N s 1 and f Health if item		Cherie 20a. Method of Disp 1 Burial 2					Place of Dispos rematory or of	sition (	Name of cer	netery,	Onap	Date	20c.	Location - Cit	y or T	own, State
Limo Page: Frant:	L	4 Donation 5	Other S	pecify:	moval from C		nsfield	i–Ec	chols	Crem						Hall, MD
Bal permii Depar Impor	4	21. Signature of Fur	neral Service	Licensee	744	M00817			and Address Thre		DITI	sfield	-Ec	hols F	. H	., P.A. 1, MD 20622
Physician	1	23a. Part I. Enter the failure. List onl			ns that cause			the mo	de of dying,	such as ca	ardiac or r	espiratory arre	est, sh	ock, or heart	4.1	Approximate Interval Between Onset and
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Box 68760, s death certificate be the attending physical of for use as the buring by significant buring and the	2	F FEMALE: 3b. Was decedent past 12 months'			. If yes, outco	ome of pregn		etal dea	ath 3 [	Ectopic	pregnanc	;y	23	d. Date of deli Month	ivery Da	ay Year
he death certificate the death certificate by the attending phyched for use as the Phycician/M		1 Yes 2 N		known 9	Pregnant a	at time of dea	ath 5 O	ther (S	Specify)				1			Į.
P.O. B that the d		Part II. Other signif	ficant condit	tions contr	ibuting to dea	th but not re	sulting in the	underly	ying cause g	iven in Par	t I.					ne cause of death?
ords, P w requires the seen signs should be defined by								_				1 Yes				bly 4 Unknown
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Ital Recipion: The sertificate rector, page		25. Was case referre	ed to medica	1						of Death (	Check on	1 Yes	- N	1 🗸	res	2 No
f Vit	2		2 No	Hospita	al: 1 Inpat Ba. Date of In		ER/Outpatient			Other <sub>4</sub>		Home 5		ence 6 🗸 0	ther:	Scene
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b entical Centification: To Re Commisted by Divisional/Me		1 Natural	5 Pend	ding	OUND: Day Aug 7, 2012	Year)	FOUND: 1735 hrs	n ijai y		es 2	le.	ubject sho				
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		2 Accident 3 Suicide	6 Cou	ld not be	8e. Place of	njury - At ho	me, farm, stre	et, fact	tory, office bi	uilding, etc		or Town, S	tate)			al Route Number, City
Hospita 4 hours Funeral	- 1 -	4 Homicide 29a. Certifier (Check only 1				arking Lot	e, death occur	rred at	the time, da	ite and plac						shington, MD
To the Hos within 24 h To the Fun completely		one) 2 🗸	Medicai Exa	miner: On th and r		amination an	d/or investiga	ition, in	my opinion,	, death occ			and pla	ace, and due t	o the	cause(s)
2		29b. Signature and	title of certifie	er				ĺ	29c, License O.C.N					Date signed (		h, Day, Year)
(2) 20	3	30. Name and addre	ess of person	who comple	eted cause of	death (Item :	23a)			<u>.</u>						70.7
10 pm		Ling Li, MD				er 900 V	V. Baltimo	re St	reet, Balti	imore, M	1D 2122	23		<u> </u>		
Stat Registra	_		AUG 1			ars Signatur	d. pa	al.	1							
DHMH 17 Rev 1/2001	1	·			7		ORIGINA	L					OCM	Ε		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Mary Alice Murphy 9:35 P M 2012 8 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 217-34-1737 1 M 2 X F 76 09/25/1935 Maryland 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Benedict 1 Yes 2X No Maryland Calvert 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7200 Knoll Place 20612 USA death . 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. If them 27 is marked other than "natural", or any injury or other traumatic avant than the state of the state. Completed by 1 Never Married 2 X Married ☐ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bessie May Higgs (Springfield) James Bertram Higgs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hughesville, MD 20637 17745 Prince Frederick Sharon Mattia / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Trinity Memorial Gardens 8/15/12 Waldorf, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols Funeral Home P.A. Signature of Funeral Service Licensee M00817 23a. Part 1. Entertue disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 30195 Three Notch Road Charlotte Hall, MD 20622 Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ CEREBRAL INFARCTION ACUTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Cordiovascular disease tensive Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last burialnding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death g | Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Chronic Obstructive Air way 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No Fibrillation 24a. Was an Atrial ate has page 2 s autopsy performed? Yes 2 X No Drabetes mellitus 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) Hospital: ျှ 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending iniury in 24 hours af er uses... he Funeral Director Aff 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🛮 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) cugan - C sunono D.50653

State

Registrar
DHMH 17 Rev 06-2011

hunchton

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

GYAN

Road

Deale

SURAWA

12-06028 Tyler Brett Mattingly

State of Maryland / Department of Health and Mental Hygiene

2012 27179

		- For State Registrar		Cer	rtificate	of.	Death			F	Reg. No.		
Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year								, ]	3. Time of Death		
Medical Examin	ег	Tyler	Brett Mat	tingly				_		August 1	1, 2012		2035 hrs
		4a. Facility Name (if not institutio Route 5 and 489	n, give street and n	umber)	_	41	b. City, Town, or Park Hall	Location of	of Death		4c. County of St. Mary		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday	)	If Under 1 Yea			8. Date of B	irth(MM/DD/YYYY		
Director		212-43-4972   1X M 2 F   17 Yrs.   Months Days Hours Min.   09/01/1994								Foreign Cou	n untry <b>Maryland</b>		
	ŀ	Usual Residence of Decedent		<u> </u>						03/01	7 - 2 2 .		
any	-	10a. State 10b. County		10c. City,	Town or Lo	ocatio	on						10d. Inside City Limits
<b>≱</b> .*	ē		Mary's				Lexingto	on Pa	rk				1 Yes 2 X No
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Director	10e. Street and Number  21465 Cameron	Court				10f. Zip Code	653			10g. Citizen of Wh	SA	ntry?
with 18 23 19 19 19 19 19 19 19 19 19 19 19 19 19	쿈	11. Marital Status		cedent Ever in U.	S. 13.		Decedent of His	panic Orig			o- 14. Race	- Americ	can Indian, Black,
item item	Funeral	1 X Never Married 2 Married 2		orces?		If Ye	s, specify Cuban	, Mexican	, Puerto R	ican, etc.)	White	, etc.	
rer d		3 Widowed 4 Div	1 Yes orced If Yes, Give Ye		1	Π,	Yes 2 🗙 No	specify:			Specify:	Whi	te
urs af	화	15. Decedent's Education (Spec	or Dates: cify only highest gra	de completed)			s Usual Occupat				16b. Kind of Bu	siness/li	ndustry
2 hou	홢	Elementary/Secondary (0-12)	College (	1-4 or 5+)	durin	g mo	st of working life.	DO NOT	use retired	d)			_
36 in 7 than	픫	12				St	tudent				High :	3cho	ol
d with	Completed	17. Father's Name (First, Middle,	Last)					18.Mother	's Name (F	irst, Middle,	Maiden Surname)	,	
D 21215-0036 should be filed within 72 hours and Mental Hygiene. 7 is marked other than "natur natic event, the Medical Exam	Be	·	ryl Matti	ing1v					Tere	sa Lv	nn Willia	ams	
	ᆰ	19a. Informant's Name/Relations	_		19b. Ma	ilina .	Address (Stree	t and Num		_	ımber, City or Tow		Zip Code)
MD 21215-0036 at 2 should be filed within 7 tth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	-	Teresa Lynn Ch		hor							on Park,		20653
C 0 5 7		20a. Method of Disposition	артти/но				ion (Name of cer			Date	20c. Location -		
		1 X Burial 2 Cremation	3 Removal f	OIII State	crematory o				_				
Pag ment tant:	Ш	4 Donation 5 Other Sp		Eve			norial Gar				2 Great		
Baltimore, pernit. Pages l a Department of He Important: If ite	- 1	21. Signature of Funeral Service	: 4/ / 1/ 4	0.	2	2. Na	me and Address	of Facility ng Le	y-Gar	diner	Funeral	Ноп	ne, P.A.
E.E.A.S CO	_1	Michael		diner		41:	590 Fenw	rick	Stree	t Leo	nardtown	, MU	20650
Physician		23a. Part I. Enter the disease, or failure. List only one cause		caused the death.	. Do not ent	er the	e mode of dying,	such as c	ardiac or r	espiratory a	rest, shock, or hea	irt	Approximate Interval Between Onset and
/Medical Examiner	- 1	Immediate Cause (Final disease	B. A Himler Levi	juries									Death
LAMIIIICI	- 1	or condition resulting in death)	Due to (or as	a consequence of	f):								
	L	Sequentially list conditions,	b										
	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause		a consequence of	f):								
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	f):							_	
cuted and transit		events resulting in deathy Last	d.										
execute an and al - tran	/Medical	UNPENDED	AMENDED										
760, ficate be exe g physician a the burial -	曑	IF FEMALE:	23c. If yes.	outcome of preg	nancy	-					23d. Date of	delivery	
876 tificat ng phy as the		23b. Was decedent pregnant in the past 12 months?				Feta	al death 3	Ectopio	c pregnanc	у	Month	D	ay Year
Box 68: death certification at the attending and for use as 1	<u>:</u>		1	nant at time of de			er (Specify)						
Bo e deal	ES		known 9 Unkn										
P.O. B es that the d igned by the	by Physiciar	Part II. Other significant condit	ions contributing t	o death but not re	esulting in t	he un	nderlying cause g	jiven in Pa	art 1.				the cause of death?
res that signed!	륑									1 Ye	es 2 🗸 No 3 [	Prob	ably 4 Unknown
ords, w requir	Completed									24a. Was			topsy findings available ompletion of cause of
e law e has	티	-								perf	orm <u>ed</u> ?	eath?	
of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b		25. Was case referred to medica	1 1				26 Place	of Death	(Check on		2 140 1	V 16	2 2 140
ital Fician: 'ician: 's certificientector, I	m۵	examiner?	Manufal.	Inpatient 2	ER/Outpat	ient		O.11	Nursing	<del></del>	Residence 6	Other	Scene
f Vi Physi er this	욘	1 Yes 2 No	28a. Date		28b. Time			v at Work			how injury occurre		. 000110
ding Ph	티	1 Natural 5 Pend	ting Aug 10	h, Day Year) , 2012	UNKNO'		'	res 2	. In		auto collision		
Sior Attend death sctor:	등		stigation Aug	11, 2012						Of Location	(Street and Number	or or Du	ral Route Number, City
Division pital or Attendi ours after death.	Certification:		d not be	ce of Injury - At ho			, ractory, office b	uliaing, et		or Town	State)		rk Hall, MD
Hospital 24 hours Funeral	죵	4 Homicide	100000	Major Road									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exceuted within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	(Check only	hysiclan: To the be miner:On the basis and manner:	of examination a									
To wit	¥ €	29b. Signature and title of certifie			_		29c. Licens	e number			29d. Date signe	d (Mor	nth, Day, Year)
		(auro 1	All On 1				O.C.I	M.E.			August 12,	2012	
	-	30. Name and address of person	who completed car	ise of death (Item	1 23a1								
43-			Assistant Medi			V. B	altimore Stre	et, Balt	imore, N	/ID 21223	3		
Sta	ate	31. Date filed (Month, Day, Year)		egistrar's Signatu	ıre	,							
Regist	_	AUG 1 5	2012	none p	7.	BV.	4/						
DHMH 17 Rev 1/20	01		OCME		ORIGI	NAL							

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amberry Ann r	nui pi	1- For State Certificate of Death Reg. No.
Physic Medical Exam		1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
- · ·		Dorchester General Hospital Cambridge Dorchester  5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year I f Under 24Hrs. 18. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Funera Director		213-98-5518 1_M 2xF 43 Yrs. Months Days Hours Min. July 2, 1969 Foreign Country) MD
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
faryland 28a-f show at once,	ē	MD Dorchester Cambridge 1 □ Yes 2 ▼ No
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examicer must be potified at once.	I Director	10e. Street and Number  3016 Steamer Run Road  10f. Zip Code  10g. Citizen of What Country?  USA
r death win	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
after d	by F.	3 Widowed 4 X Divorced If Yes 2 X No 1 Yes 2 X No specify: Specify: White
2 hours "natur	ted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
5-0036 lied within 72 hours after Hygiene. the Medical Examice:	Completed	homemaker own home
21215-0036 ould be filed within 72 h I Mental Hygiene. s marked other than "n ic event, the Medical E	B	17. Father's Name (First, Middle, Last)  Melvin A. Murphy  18. Mother's Name (First, Middle, Maiden Surname)  Frances Burton
Baltimore, MD 2' permit. Pages 1 and 2 should Department of Health and Me Important: If item 27 is ms injury or other traumatic.	입	19a. Informant's Name/Relationship (Type, Print) Dustin R. Collison Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5311 River Drive, Cambridge, MD 21613
Ore, ges l an t of Hea t If itel		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  Dorchester Mem. Park 8/22/12 Cambridge. MD
Baltimore, permit. Pages 1 ar Department of He Important: If ite		4 Donation 5 Other Specify.
		700 Locust St., Cambridge, MD 21613
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Complications of Liver Cirrhosis due to Hepatitis C Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. virus and chronic alcohol abuse  Due to (or as a consequence of):
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
60, ate be executed obysician and te burial - transit	al Ex	Stories southing in death, Edst
O, e be exe ysician burial -	edic	IF FEMALE:  23c. If yes, outcome of pregnancy  23d. Date of delivery
5876 srtificat ling phy	an/M	23b. Was decedent pregnant in the past 12 months?
Box 6876 re death certificat the attending phy red for use as the	Physician/I	4 Pregnant at time of death 5 Other (Specify) 9 Unknown
hat the ed by the letached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death?
rds, P.C requires that been signed hould be deta		1 Yes 2 No 3 Probably 4 V Unknown  24a. Was an 24b. Were autopsy findings available
COFC e law re e has be e 2 sho	ompleted	autopsy prior to completion of cause of performed? death?
Vital Rec ysician: The l his certificate l director, page	O	1 ✓ Yes 2 No 1 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one)
· Vita Physicia r this ce	To Be	examiner? 1  Yes 2 No  Hospital: 1 Inpatient 2  ER/Outpatient 3 DOA  Other 1 Nursing Home 5 Residence 6 Other:
on of on of on of the the transfer of the tran		27. Manner of Death  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No
Division tal or Attendii rs after death.	ertification	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
DIV ospital or hours afte ineral Dir y filled in	Cert	4 Homicide determined (Specify)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 House after death.  To the Funeral Division After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal - transi	Medical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,
7 × 5 8	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Mln Brasself, MD O.C.M.E. August 18, 2012
	- 1	30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
S Regis		31. Date filed (Month, Day Year)  AUG 2 0 2012  AUG 2 0 2012
itegis	النعد	LIAM A PAIR AND A LA LA

			State		artment of Health a	and Mental Hy	giene Reg. No. 201	2 27181			
			Registrar  1. Decedent's Name (First, Middle, Last)		tincate of Death	2. Date of Dea		3. Time of Death			
	Physicia Medic		Clara Leola McKnett			August	1	8:17 a. <sub>M</sub>			
	Examin	er	4a. Facility Name (if not institution, give street and number) 5418 Cannon Road		4b. City, Town, or Location o		4c. County of Dea	chester			
	Funeral			age (In yrs. last birthday)	If Under 1 Year If Under 2	24 Hrs. 8. Date of Birt	h 9. B	rthplace (State or Foreign			
	Director		216-38-8731 1 □ M 2 🔀 F	95 Yrs.	Months Days Hours	Min. (Month, Day Oct. 10		Maryland			
	and show	o	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo				10d. Inside City Limits			
0	Maryli 28a-f notified	Director	MD Dorchester	<u> </u>	Cambri	.dge		1 🗌 Yes 2 🕱 No			
	s 23a or	Funeral D	10e. Street and Number 5418 Cannon Road		10f. Zip Code 21613		10g. Citizen of What C	ountry?			
9036	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f show c event, the Medical Examiner must be notified at	ام ا	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Armed Forces  1 □ Yes 2 □ If Yes, Give Year or Dates.	? <b>X</b> No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 X No Specify:	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - Am Black, Whi Specify: <b>N</b>				
21215-0036	ithin 72 hou ene. • than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or	(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Seamstress garment m						
land 2	permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, the once,	SeamStress garmer  Port of the control of the contr									
, Mary	id 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Mildred E. McKnett daug	r or Rural Route Numbe Cambridge,		lip Code)					
Baltimore, Maryland	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1		matory or other place)	Date 8/11/12	20c. Location - City of East New M	·			
Balt	permit. Departimont import any inj		21. Signature of Funeral Service Licensee	7	2. Name and Address of Facility 00 Locust St.,	Thomas Fur Cambridge	neral Home , MD 21613	P.A.			
ا ــــا	Physician/		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	ed the death. Do not ent ne.	er the mode of dying, such as o	cardiac or respiratory and	rest,	Approximate Interval Between Onset and Death			
U	Medical Examiner		resulting in death)  Due to (or a	s a c∜nsequence of):	1, 1, 1, 1, 1						
	ted I ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	s a conse uence of:							
09	ate be executed hysician and the burial-transit	dical Ex	that initiated events resulting in death) Last  C. Due to (or a	s a consequence of):							
9289	ificate ng phy as the	Med	IF FEMALE:								
	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant 23c. If yes, outcom	n 2 🗌 Fetal death 3 [ t at time of death 5 [	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of d Month	elivery Day Year			
Js, P.O.	The law requires that the ate has been signed by the page 2 should be detach	by	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I	23e. Did to	obacco use contribute of Yes 2 No 3 🗆	to the cause of death?			
	The law rec cate has bee page 2 shc	Completed	osy prior to rmed? death?	utopsy findings available completion of cause of es 2 🔊 No							
ital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Othors	th (Check only one)					
of V	y Physer this eral di	e: To	27. Manner of Death 28a. Date of in	atient 2 ER/Outpatie	nt 3 □ DOA	rsing Home PResident 28d. Describe h	dence 6 U Other (Spenow injury occurred	cify)			
on (	Attending I r death. sctor: After by the funer	ficat	1 Natural 5 Pending (Month, E	Day, Year) injury	work? M 1 ☐ Yes 2 ☐	No					
>	al or Attencs s after death Il Director: A	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of It building, €	njury - At home, farm, str etc. <i>(Specify)</i>	reet, factory, office	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,			
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Medical Examiner: On the basis of State only one) 3 Certifying Nurse Practitioner: To	fexamination and/or inves	stigation, in my opinion, death oc	curred at the time, date a	ind place, and due to the	cause(s) and manner stated.			
	To the within 2 To the comple		29b. Signature and title of fertifier	>	29c. License number 145179	3	29d. Date signed (Mon	th, Day, Year)			
	10		30. Name and address of person who completed cause of 2 VGENE NEWMICE	death (Item 23a) (Type,	Parks ter Av	e Svite1	Campad	EMD 21613			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	and	/					

			Please Type or Print in Bla State of Maryland						Legible	•
		•	For State Of Maryland / State Registrar		ificate of E			Reg. No.	2012	27182
			Decedent's Name (First, Middle, Last)				2. Date of Dea	ath		3. Time of Death
	Physicia Medic		DOLL 13. MARS	DEA	J		Month &	Day	Year 12	6:20 PM
	Examin		4a. Facility Name (if not institution, give street and number)		. 1	Location of Death			County of Deat	A
N-Market C	Funeral		MANDRIN NPT CARE CENT 5. Social Security Number 6. Sex 7. Age (In yrs. last b		If Under 1 Year	WOOD If Under 24 Hrs.	8. Date of Birt	h		ARVNOEL thplace (State or Foreign
в	Director		541-34-8283 1□M2□XF	Yrs.	Months Days	Hours Min.	(Month, Day			raska
	nd how at	7	Usual Residence of Decedent         77           10a. State         10b. County         10c. City, To	wn or Loca	ation		Sep. 5,	193	4 INED	10d. Inside City Limits
	farylar Ba-f s tified	ecto	Maryland   Prince George's   Bowie	٥						1 □ <b>X</b> Yes 2 □ No
	the Na or 2	Ö	10e. Street and Number		10f. Zip Code			10g. Citiz	zen of What Co	ountry?
	h with	Funeral Director	12220 Quadrille Lane		20720			_USA		
<b>~</b>	or iter niner	by Fu	11. Marital Status  1  Never Married 2  Married  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No	13. Wa	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
Maryland 21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	ed b	3 Awidowed 4 Divorced Year or Dates.	1 [	Yes 2 X No	Specify:		8	Specify: Whi	ite
5-0	2 hou "natu edical	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	(Give kir.	nt's Usual Occupa	ation luring most of work	ing	16b. Kir	nd of Business	
12	within 72 giene. her than t, the Me	Com	Elementary/Secondary (0-12) College (1-4 or 5+)	iife. DO ome Ma	NOT use retired)			Own	Home	
9	should be filed wii and Mental Hygie is marked other aumatic event, the	Be	17. Father's Name (First, Middle, Last)	JINC TIC	u KC1	18. Mother's Nam	e (First, Middle,			
ylar	ild be file Mental narked c	잍	Floyd Brooks			Helen Ea	ırly			
Nan	and 2 should be filed within 72 hour f Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, <u>the Medical</u>			9b. Mailing	Address (Street a	and Number or Run	al Route Number	r, City or 1	Town, State, Zi	p Code)
	1 and 2 of Health item 27 other tr				Keenland tion (Name of	<u>Court Fo</u>	rest Hi		MD 2105 cation - City or	
Baltimore,	permit. Page 1 Department of Important: If it eny injury or o		1 Burial 2 🕅 Cremation 3 D Removal from State ceme	tery, crema	ntory or other place	e)			orf, ME	
altii	permit. F Departm Importa eny inju		21. Signature of Funeral Service Licensee	22.1	matory Name and Addres	ss of Facility Rob	ert E.	Evan	s Funer	ral Home
<u> </u>	9 E E E		alla ho	16	6000 Anna	apolis Ro	ad Bowi	e, M		
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	o not enter	. 1					Approximate Interval Between Onset and Death
2	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence)		H-	PERTE	PEIDA	/		eus
-	Examiner			ح د	D					years
	n #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of):						
	be executed sician and burial-transit	Exan	Cause (Disease or injury that initiated events c. Due to (or as a consequence Due to (	e of):						
0	e be ey	ᇙᅵᇙᅵ	d							
Box 68760	res that the death certificate be signed by the attending phys; d be detached for use as the	Completed by Physician/Medic	IF FEMALE:					-1		
9 X G	ath cer attendi	ian/	23b. Was decedent pregnant in the past 12 months? in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal de		Ectopic pregnanc Other (specify)	:y		2	23d. Date of de Month	livery Day Year
	he deg y the g ached	hysi	1	1 30	Other (specify)					
P.O.	that t	by P	Part II. Other significant conditions contributing to death but not esulting	g in the und	derlying cause giv	=		obacco us	se contribute to	the cause of death?
rds,	v requires been signatures	ted	CONCESTIVE HE	AR	-+	ALUK	۱ 🗆	Yes 2	□ No 3 □ P	robably 4 X Unknown
S	law re has be ge 2 st	mple			-		24a. Was autop	osv	prior to	topsy findings available completion of cause of
Ä	n: The ificate or, pag	ပ္ပိ	25. Was case referred to medical		ae Die	ace of Death (Chec		rmed? 2 No	1 ☐ Ye	s 2 No
Vita	ysicia is cert direct	To Be	examiner? 1  Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatient	Otho	ar:	ome 5 🗆 Resid	dence 6	Other (Spec	ify MICC
of	ng Ph fter th uneral	te:		o. Time of injury	28c. Injury work	/ at	28d. Describe h			Hospice
ion	ttendii death. ctor: At y the fu	tifica	2 Accident Investigation 3 Suicide 6 Could not be	form stree		Yes 2 ☐ No	006 14: 00	\		and Davida Maraka
Division of Vital Records,	after Direct	Çe	4 ☐ Homicide determined 288. Place of Injury - At nome, building, etc. (Specify)	iarm, stree	et, ractory, office		City or Tow		i Number or Hu	ral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate Ewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical Certificate:	29a. Certifier (Check (Check 2  Medical Examiner: On the basis of examination and	e, death oc	curred at the time	e, date and place, a	nd due to the ca	ause(s) an	nd manner as st	tated.
	the Hithin 24 the Figure 14 th	Me	only one) 3			he time, date and pl	ace, and due to t	he cause(s	s) and manner a	as stated.
	<b>7</b> ≥ <b>2</b> 5		PENS & Harri	<b>~</b>	29c. License	DO03			e signed (Mont	)2
	No		30. Name and address of person who completed cause of death (Item 20%)	(Type, Pri			. 1		-1-1	21401
	W			45	DEFE	USE	Han	~ K-7	+ AN	INAP
	Stat Registra		31. Date filed (Month, Day, Year) AUG 0 8 2012 32. Registrar's Signature	1	adel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G9/06/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Allegust 7 pay 2012 Year ANA GRISELDA MADJID 10:10 A<sub>M</sub> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Casey- House Montgomery Hospice Derwood Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) ept. 9,1984 115-68-9315 Months Hours Min. New York Director 1 □ M 2 💢 F 27 Sept. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I them 27 is marked other then "natural", or items 23a or 28a-f show other treumetic event, the Medical Examination must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Germantown 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20874 United States 19911 Wyman Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 X Married ੬ Maryland 21215-0036 1 X Yes 2 □ No Specify: Salvadoran White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Medical Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ana Quintanilla Oscar Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abdul Madjid (Spouse) 19911 Wyman Way Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Unlen 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If its
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Aug-28-2012 Arlington, VA Arlington National 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park DR. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Abdominal Sarcoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlah-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice 2 X No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 2 🔲 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficiency Projection. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 August 7, 2102 10-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. G. Geoffrey Coleman M.D. 6001 Muncaster Mill Road, Rockville, MD 20855

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

AUG 0 8 2012

Baltimore,

of Vital

Division

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10, 2012 Year **Physician** 8:30p M John Ezra MUSEY, JR. August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Golden Living Center Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Months | Days | Hours | Min. | April 9,1933 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Maryland 79 Yrs Director 217-30-6055 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "naturel", or items 23s or 28s-f show or other traumatic event, the Mudical Examiner must be notified at Washington Maryland Hagerstown 1 ☐ Yes 24 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 810 Medway Road 21740 U.S.A. death Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Menial Hygiene. Int: If itsm 27 is marked other than "naturel", or Its 1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) engine tester truck mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Ezra Musey Hazel Bowman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace N. Musey - wife 810 Medway Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or Hagerstown Crematory Aug. 2013 Hagerstown, Maryland 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MIC /Medical Due to (or as a consequence of) Examiner OT ONAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown cate has been signed , page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 2 No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? tor: After this certific the funeral director, Be 26. Place of Death (Check only one) 1 Yes 2 1 Other. Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Z Natural 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert State 29a. Certifier (Check only one) 29b. Signature and Alle of certifier D0063233 address of person who completed cause of death (Item 23a) (Type, Print) TIN - 2 Northern Aue 1ahmod MI) 520 C 31. Date filed (Month Days 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ 2012 Year Month Day Michael A. Nickerson Ju1v 28 12:18 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Muth Assisted Living Facility Ceci1 E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🛛 M 2 🗌 Days (Month, Day, Year) 9/18/1962 Director 49 212-78-1332 Usual Residence of Decedent or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 592 Fletchwood Road 21921 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or 1 X Never Married 2 ☐ Married Yes 2 X No Completed by Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 0 Disabled N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Baynard Nickerson Carolyn Gott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Blevins - mother 727 Mt. Nebo Road, Chesapeake City, MD 21915 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ö 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Bethel Cemetery 8/2/2012 4 Donation 5 Other (Specify) Chesapeake City, MD 21. Signature Service Licensee 22. Name and Address of Facility R.T.Foard Funeral Home, PA 259 East Main Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): 16 ul or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Year Dav a Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 X No 1 ☐ Yes 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 X No Assisted ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062190 SHITEA, CHESAPEAKE CITY, MD 21915

State Registrar

HERMAN HWY

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUGUSTINE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lynn 2046 Jimmie Neal 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland Social Security Number Age (In vrs. last birthday) 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Months Hours Director 218-78-6570 1 □ M 2 🏻 F New York 10/19/1960 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Allegany Cumberland 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral USA 217 E. Union Street 21502 items 2 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Yes 2X No ō 9 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. other than " life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Neal James Gilbert Marjorie Elizabeth Strickland ge 1 and 2 should be it of Health and Men other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Carolyn E. Neal-Harden /Daughter 217 E. Union Street, Cumberland, MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Department c Important: If any injury or injury or Cumberland Crematory 08/01/2012 Cumberland, MD Donation 5 ☐ Other (Specify) of Funeral \$ 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) sician Physician/Medical Records, P.O. Box 68760 physi the b as 1 ed by the attending | IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for in the past 12 months2 Month Year Pregnant at time of death 1 Yes 2 g Unknown 2 100 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page certificate ☐ Yes 1 Yes 2 No Division of Vital director, 25. Was case referred to me al 26. Place of Death (Check only one) Be Hospital Other: 2 🗓 No 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? injury atural 5 Pending b 24 hours after death.
E Funeral Director: Ailetely filled in by the full Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the nd title of ce 101 29b. Signature 29d. Date signed (Month, Day, Year) 0

Registrar
DHMH 17 Rev 06-2011

State

915 Seton Drive, Cumberland, MD

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Joseph Kariyil, M.D.,

Month, Day, Year) AUG 0 1 2012

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year ONEIL WILLIAM 12:56 PM AUG 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 217-60-6707 60 Yrs. Director 1 □XM 2 □ F 02/19/1952 Washington, DC Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d. Inside City Limits with the Maryland Director notified 28a-f 1 ☐ Yes 2XXXNo Charles Waldorf MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a 15021 Truman Manor Lane 20601 USA items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black White etc. þ 1 Never Married 2 M Married ö Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The 12 is marked other than "natural", or any it item 27 is marked other than "natural", or or other traumatic event, the Medical Examinury or other traumatic event, the Medical Examin 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Self-Employed/ life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Music Center Musical Instrument Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Aloysius O'Neil Marie Dorothy Buckler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. O'Neil / Wife 15021 Truman Manor Lane, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of once. cemetery crematory or other place Boyds Presbyterian Church Cemetery 1 X Burial 2 Cremation 3 Removal from State 08/17/2012 Boyds, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 21. Signature of F #M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ HYPOXIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner MONTH SYNDROME I DIOPATHIC PNEUMONIA Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) 3 YEARS Cause (Disease or injury that initiated events resulting in death) Last LEUKEMIA the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

RMV State

DANIEL SMITH 22 S. Greene St.
31. Date filed (Month, Day, Year) 32 registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ΜD

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Registrar

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Baltimore,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) August  $13^{\text{Day}}$ Physician/ 2012 ea 6:45 p.m. Peeler Elizabeth Cecilia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year, **Director** 212-30-4979 1 🗆 M 2 🛣 F 10/22/1932 Maryland Usual Residence of Decede 79 28a-f show 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1X Yes 2 No Maryland St. Mary's Leonardtown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 25450 Point Lookout Road, Apt. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2 XNo Specify nan "natural", o Medical Exan If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home should be filed with and Mental Hygien is marked other ti 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Cecilia Miedzinski Killian Laschalt traumatic Department of Health and Important: If item 27 is n any injury or other traumone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25450 Point Lookout Road, Apt. 4, Leonardtown, MD Clarence Peeler/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Joseph's Cemetery 08/18/2012 Morganza, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Signature of Funeral Style Lig Margaret Hicks M01631 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Due to (or as a conseque ce of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a conse unce of) Examine -te Cause (Disease or injury that initiated events and Due o (o as a consequence of) resulting in death) Last physician s the burial Physician/Medical certificate be P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 1 Yes 2 No signed by the at Id be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 Director: After this certificate Nr Yes 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မူ filled in by the funeral 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 5 Pending 1. Natural after death Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

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(Check

29b. Signature and title of certifier

Youngsik Moon,

31. Date filed (Month, Day, Year)

24435 Mervell Dean Road, Hollywood, MD

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

29d. Date signed (Month, Day, Year)

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21. Signature of Sperial Santos transee Rose Bank Cemetery Rising Sun, Maryland 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ DETENTI Medical resulting in death) Due to (or as a consequence of) Examiner PULMONARY Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and I-transit di Due to (or as a consequence of): physician are the burial-t Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Were autopsy findings available prior to completion of cause of 24a. Was an autonsv page death? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ■Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie f. N Nonde IS 08/06/12

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

Deneva A. Sall

Dr. Narayana Pula, MD, 126A East High Street, Elkton, Maryland

32. Registrar's Signature

DOO 65733

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, DaAUG 07

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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er		
ine	compieted iliteu in by the funeral director, page z should be detached for use as the burial-transit	7
ım	To the Funeral Director: After this certificate has been signed by the attending physician and	:1
ĸa	within 24 hours after death.	

-	For State Of IVIal State Registrar  1. Decedent's Name (First, Middle, Last)		ertificate of D		R. 2. Date of Deat	<sub>eg. No.</sub> 2012						
n/ al	Marian W. Patterson				July July	1 <sup>2</sup> 2012	3. Time of Death 9:40 P M					
er	4a. Facility Name (if not institution, give street and number) Harmony Hall		4b. City, Town, or <b>Columbi</b>	Location of Death		4c. County of Death Howard Co	bunty					
	299-03-8587 1 □ M 2 X F	<i>98</i> Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 21	9. Birt Coo. 1914 Oh:	hplace (State or Foreign Intry) LO					
Director		0c. City, Town or <b>Dayton</b>	Location				10d. Inside City Limits 1 ☐ Yes 2 🌠 No					
Funeral Di	10e. Street and Number 4231 Linthicum Road		10f. Zip Code 21036			Og. Citizen of What Co Inited Stat						
þ	11. Marital Status  1 □ Never Married 2 □ Married  3 Ⅸ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☒ No Fee Status  12. Was Decedent Eve Armed Forces?  1 □ Yes 2 ☒ No Fee Status  Year or Dates.		3. Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 🏋 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh						
To Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Giv	cedent's Usual Occupa ve kind of work done d DO NOT use retired) emaker		ing	own home	Industry					
	17. Father's Name (First, Middle, Last) Alvin D. Wampler	•		18. Mother's Name Nellie	e (First, Middle, M Bay	aiden Surname)						
	19a. Informant's Name/Relationship (Type, Print) David B. Patterson / son		ailing Address (Street a			City or Town, State, Zip Maryland						
	20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)	cemetery, c	sposition (Name of rematory or other place <b>Cremation</b>	) July 2	7 16. 1	20c. Location - City or Hampstead,						
	21. Signature of Funeral Service Licensee  Handa L Lemme	20,741	22. Name and Addres 934 South I	s of Facility El Main Stre	ine Fune et Hamp	eral Home ostead, Mar	yland 21074					
	23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final			g, such as cardiac d	or respiratory arre	st,	Approximate Interval Between Onset and Death					
	disease or condition resulting in death)  A a consequence of):  Due to (or as a consequence of):											
Examiner	Sequentially list conditions, if any, because the cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):											
ledical I	d											
Physician/M												
by	23e, Did tobacco use contribute to											
Completed					24a. Was ar autops perform 1 \square Yes 2	y prior to o ned? death?	topsy findings available completion of cause of					
To Be	25. Was case referred to medical examiner?  1  Yes 2 X No Hospital:	t 2 🗆 ER/Outpat	Otho	r:		nce 6 Other (Speci	(6.)					
	27. Manner of Death  1 X Natural  5 Pending  28a. Date of injury (Month, Day, 1)	28b. Time	of 28c. Injury work	at ?	28d. Describe ho		<u> </u>					
Certificate:												
Medical	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 3 Certifying Nurse Practioner: To the best of examiner: On the basis of examiner: On the basis of examiner: On the basis of examiner: To the best of m (Check only one) 1 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Physician: To the best of m (Ch	mination and/or inv	estigation, in my opinio	n, death occurred at	the time, date and	d place, and due to the o	cause(s) and manner stated					
	29c. Signature and title of certifier  Whichelle Klessock   29c. License number   29d. Date signed (Month, Day, Year)  July 16, 2012											
	30. Name and address of person who completed cause of dea Michelle Klima, CRNP 633-		Lane, #103	Colum	bia, Mar	ryland 2104	4					
е	31. Date filed (Month, Day, Year) 32 Registrar's	Signature	la V I									

	1- For State Registrar	Certifica	te of Death		Reg. N	_ 20	12	411
	Decedent's Name (First, Middle,Last)	mile Picet			Date of Death Month Day August 13, 20		3. Time o	
	Michael Anthony E  4a. Facility Name (if not institution, give street  47722 My Way	mile Picot and number)	4b. City, Town, or L St. Inigoes			4c. County of De St. Mary's	eath	
Funeral Director	5. Social Security Number 6. Sex 1X M 2	7. Age (In yrs, last birth	day) If Under 1 Year Months Days Yrs.	Hours Min	8. Date of Birth (M	For	Birthplace (St reign Country) E1	
ow any	Usual Residence of Decedent  10a. State  10b. County	10c. City, Town o		-			10d. Insid	de City Limit
n with the Maryland ms 23a or 28a-f show he notified at once. eral Director	Maryland St. Mary's  10e Street and Number	St. Ini	10f. Zip Code	-	10g. C	Citizen of What C		
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must he notified at once :ed by Funeral Director	1 Never Married 2 Married An	ned Forces?	20684  13. Was Decedent of Hisp If Yes, specify Cuban,		cify Yes or No-	14. Race - An White, etc	nerican Indian	, Black,
hours after d	3 Widowed 4 Divorced If Yes, G or Dates  15. Decedent's Education (Specify only higher	ve Year : st grade completed) 16a. D	1 Yes 2 No ecedent's Usual Occupation uring most of working life. I	n (Give kind of wo		Specify: What is the state of t	nite ss/Industry	
High within 72 hour. Hygiene. dother than "natu , the Medical Exan	Elementary/Secondary (0-12) Coll  11  17. Father's Name (First, Middle, Last)	ege (1-4 or 5+)	keting Consu	ıltant		wn Busin	nėss	
d Mental Hy d Mental Hy s marked of tic event, th	Ron Picot  19a. Informant's Name/Relationship (Type, Prir	t) 19b.	Mailing Address (Street	Iris Da	phne Ru	ff	ate, Zip Code	)
s I and 2 sn f Health an if item 27 i er trauma	Sarah Kirkby  20a. Method of Disposition  1 Burial 2 X Cremation 3 Rem	20b. Place of	O. Box F-417 Disposition (Name of ceme y or other place)	779, Free	port, GB	Bahama Location - City	a.S or Town, Stat	e
permit. Fage Department o Important: injury or oth	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Brinsfi	eld-Echols (	of Facility Brin	sfield F	uneral H	Home, H	P.A.
3000	Edward N. Brinsfield 23a. Part I. Enter the disease, or complications	Jr. M00052	22955 Holly	rwood Roa	d, Leona:	rdtown,	MD 206	
/ledical		hol and Mixed					Betwee	
Medical aminer Jeuiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Experimentally in Cause.  Due to (conditions) in the conditions of the conditio						Betwee	n Onset and
sician and missis and	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause Erac Unarrhying Cause (Disease or injury that initiated events resulting in death) Last  ME UNPENDED  AMEN  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Vos. 2 No. 9 Unknown	tho 1 and Mixed or as a consequence of): or as	Drug Intoxio	eation	<b>Sm</b>	3d. Date of deliv Month	Betwee	n Onset and
sician and sician and until - transit and until - transit and until - transit and edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause Erac Unarrhying Cause (Disease or injury that initiated events resulting in death) Last  ME UNPENDED  AMEN  FFEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Vos. 2 No. 9 Unknown	hol and Mixed or as a consequence of): or as a	Drug Intoxic  ,per me,g931  Grade Gr	9-6-12 Ectopic pregnance	Sm 2	3d. Date of deliv	ery Day	Year
sician and missis and	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cause Ener Underlying Caus (Disease or injury that initiated events resulting in death) Last  ME UNPENDED  AMEN  FFEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Unknown	hol and Mixed or as a consequence of): or as a	Drug Intoxic  ,per me,g931  Grade Gr	9-6-12 Ectopic pregnance	Sm 2	3d. Date of deliv Month  o use contribute  ✓ No 3 Pereprior to death	ery Day  to the cause of crobably 4 autopsy finding of completion of com	Year  Vear  Unknown  Ogs available
sician and missis and	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cuse Englishing Couse (Disease or injury that initiated events resulting in death) Last  Last  UNPENDED  AMEN  FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9  Part II. Other significant conditions  Contributions  Contributions	hol and Mixed or as a consequence of): or as a	Drug Intoxic  ,per me,g931  Fetal death	9-6-12 Ectopic pregnance en in Part I.  f Death (Check onlither, Wursing H	y  23e. Did tobacc  1 Yes 2  24a. Was an autopsy performed' 1 Yes 2  y one)  Home 5 Resid	3d. Date of delive Month  o use contribute  No 3 Property Amount of the prior to death o	ery Day  to the cause of robably 4 autopsy finding of completion of ? Yes 2	Year  Year  Unknown  Unsavailable of cause of
After this certificate has been signed by the attending physician and fineral director, page 2 should be detached for use as the burial - transit of 30.  To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate (Disease or injury that initiated events resulting in death) Last  LIMITED AMEN  TERMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 9 Part II. Other significant conditions contributions  25. Was case referred to medical examiner?  1 Yes 2 No 9 Hospital: 1 Pending Investigation 1 Pending Investigation 1 Pending Investigation 2 Pending Investigation 3 Suicide 6 Could not be	hol and Mixed or as a consequence of):  or a	Drug Intoxic  ,per me,g931  Fetal death 3 Other (Specify)  n the underlying cause giv  26.Place o patient 3 DOA O me of Injury	eation  9-6-12  Ectopic pregnance en in Part I.  f Death (Check onlither; Nursing I at Work? s 2 X No ince	23e. Did tobacc 1 Yes 2 24a. Was an autopsy performed 1 Yes 2 Yes 2 Yone) Home 5 Resided B. Describe how in tention and autopsy performed to autopsy perf	3d. Date of delive Month  o use contribute  No 3 Property No 1 Property	ery Day  to the cause of robably 4  autopsy findir of completion of	Year  Year  On the second of t
rours after death.  formal Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial -transit of Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate Cuse Engly Underlying Cause (Disease or injury that initiated events resulting in death) Last  W. UNPENDED  AMEN  IF FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contribution  25. Was case referred to medical examiner?  1 Yes 2 No  Part II. Other significant conditions  Contribution  26. Hospital: 1  27. Manner of Death  1 Natural 5 Pending Investigation  28a. Certifier (Sp. Could not be determined)  29a. Certifier 1 Certifying Physician: To the condition of the determined of the condition of the conditi	hol and Mixed or as a consequence of):  or a	Prug Intoxic  per me,g931  Fetal death 3 Other (Specify)  126.Place of Dotatient 3 DOA  DOA  The of Injury 28c. Injury 12:21 pm  The street, factory, office builting theme	eation  9-6-12  Ectopic pregnance en in Part I.  f Death (Check onlither, Nursing I at Work? s 2 X No interest No	23e. Did tobaco  1 Yes 2  24a. Was an autopsy 1 Yes 2  Prome 5 Resid  3d. Describe how in tention of Location of Location (Street or Town, State) aint Ini et to the cause(s) a	3d. Date of delive Month  o use contribute  No 3 Portion to death No 1 Other death No 1 Ingest And Number or 147722 My Boes, MD. and manner as st	ery Day  to the cause of robably 4 autopsy finding of completion of autopsy finding of completion of the cause of the caus	Year  Year  On the second of t
vitin 24 hours after death.  You be repaired at the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit of detached for use as the burial - transit of detached for use as the burial - transit of detached for use as the burial - transit of detached by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate (Disease or injury that initiated events resulting in death) Last  LIMPENDED  AMEN  FEMALE:  3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 Part II. Other significant conditions  Contributions  25c. Was case referred to medical examiner?  1 Yes 2 No 9 Unknown 9 Hospital: 1 Pending Investigation 1 Natural 5 Pending Investigation 28e (Sp. 29a Certifier 1 Certifying Physician: To the one) 2 Medical Examiner: On the tensor of the condition of the determined 1 Physician: To the one) 2 Medical Examiner: On the tensor of the condition of the determined 1 Physician: To the one) 2 Medical Examiner: On the tensor of the condition of the determined 1 Physician: To the one) 2 Medical Examiner: On the tensor of the condition of the determined 1 Physician: To the condition of the determined 1 Physician of the condition of the	hol and Mixed or as a consequence of):  or a	Prug Intoxic  per me,g931  Fetal death 3 Other (Specify)  126.Place of Dotatient 3 DOA  DOA  The of Injury 28c. Injury 12:21 pm  The street, factory, office builting theme	eation  9-6-12  Ectopic pregnance en in Part I.  f Death (Check onlither, Nursing Is at Work? s 2 No net liding, etc. 26 s and place, and dute the occurred at the number	23e. Did tobaco  1 Yes 2  24a. Was an autopsy performed from 5 Resides and performed from the total from the to	3d. Date of delive Month  o use contribute  No 3 Pour death No 1 Other dea	ery Day  to the cause of robably 4  autopsy finding of completion of autopsy finding of au	Year  Year  of death?  Unknown  In the second of the secon
within 24 hours after death.  To the Foureral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit of Medical Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate couse. En of Underlying Cause (Disease or injury that initiated events resulting in death) Last  W. UNPENDED  AMEN  IF FEMALE:  3b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending Investigation 28a.  28a. Certifier 1  Certifying Physician: To the conditions of Could not be determined (Sp. 28a). Certifier 1  Certifying Physician: To the conditions of Could not be determined (Sp. 28a). Signature and title of certifier	hol and Mixed or as a consequence of):  or a	Prug Intoxic  per me,g931  Fetal death 3 Other (Specify)  n the underlying cause give  26.Place of patient 3 DOA  per of Injury 28c. Injury 1 Ye  n, street, factory, office builting Home  accourred at the time, date estigation, in my opinion, compared to C.C.M	eation  9-6-12  Ectopic pregnance  en in Part I.  f Death (Check onlither   Nursing II  at Work?  5 2 X No II  liding, etc. 26  e and place, and due the occurred at the number  E.	23e. Did tobaco  1  Yes 2  24a. Was an autopsy performed'  1  Yes 2  y one)  Home 5  Resid  3d. Describe how in tention (Street or Town, State)  aint Ini  te to the cause(s) a ne time, date and p	3d. Date of delive Month  o use contribute  No 3 P  24b. Were prior to death 1 dence 6 Otto 1 inges  and Number or 147722 My  goes, MD  and manner as stellace, and due to 1. Date signed (A. August 1.)	ery Day  to the cause of robably 4  autopsy finding of completion of autopsy finding of au	Year  Year  of death?  Unknown  In the second of the secon

Physici Medi Exami Funera Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit Division of Vital Records, P.O. Box 68760

	Please Type or Pri						Legib	le.			
	For State of M	,	artment of Heal		ental Hyg	giene					
	Registrar  1. Decedent's Name (First, Middle, Last)	Cer	tificate of Deat	th I		Reg. No.	20	12 21	19.		
an/	Carol	Dan	-6/11		2. Date of Deat Month	Day		3. Time of De 21 3 5	eath M		
cal ner	4a. Facility Name (if not institution, give street and number)	1(2)	4b. City, Town, or Location of Death  4c. County of Death								
	The Johns Hopkins Hospita	J	Baltimor	e Cita	(		,				
	5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday)		nder 24 Hrs.	<ol> <li>Date of Birth (Month, Day,</li> </ol>		9.	Birthplace (State or F Country)	oreign		
	220-34-3658 1 □ M 2 🖾 F Usual Residence of Decedent	72 Yrs.			02/06/	1940	) Wa	shington,	DC		
ţ	10a. State 10b. County	10d. Inside City	Limits								
)irec	Maryland Worcester	Berlin						1 \( \text{Yes 2} \)	⊠ No		
Funeral Director	10e. Street and Number		10f. Zip Code				zen of What				
i.e	8382 South Longboat Way  11. Marital Status 12. Was Decedent 8	ver in U.S. 13. V	21811 Was Decedent of Hispanic	o Origin? (Spec	ifv Yes or No-	_		States American Indian,			
۾ا	1 ☐ Never Married 2 🔀 Married Armed Forces?	No	Was Decedent of Hispanic f Yes, specify Cuban, Mex		lican, etc.)		Black, W	Vhite, etc.			
ted	3 Widowed 4 Divorced If Yes, Give Year or Dates.		∏ Yes 2 🛣 No Spe	еспу:		S	Specify:	White			
Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation kind of work done during i O NOT use retired)	most of working	g	16b. Kin	nd of Busine	ess/Industry			
S	Elementary/Secondary (0-12) College (1-4 or 5	+)	ousewife				Home				
o Be	17. Father's Name (First, Middle, Last)	·	18. N	fother's Name	(First, Middle, N	∄aiden Su	urname)				
은	William Strasser				Minnie		Lzabet				
	19a. Informant's Name/Relationship (Type, Print)	I	g Address (Street and Nu								
	John H. Parsly/Spouse 20a. Method of Disposition	20b. Place of Dispo	South Longb sition (Name of					y or Town, State			
	1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		natory or other place) old Cemetery	08/09				i, Marylan	d		
	21. Si inature of Funeral Service Licensee		. Name and Address of Fa					i, mary ran			
	Medenalle		East Deer				sburg	<u>,</u> MD. 2087	7		
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final				respiratory arre	est,		Approximate Interval Between Onset and Dea			
	disease or condition resulting in death)  A S C Pue to (or one	ULAR MY	1ELOPATA	+ Y				Oriset and Dea	101		
ı		consequence oi):									
Examiner	eause. Enter Underlying	consequence of):						Die .			
xan	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a	consequence of):									
		oonooquonoo oij.									
<b>Nedi</b>	d					-					
an/N	IF FEMALE: 23b. Was decedent pregnant  1 □ Live Birth	of pregnancy 2  Fetal death 3	Ectopic pregnancy			23	3d. Date of	delivery			
Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown  1 ☐ Live Birth  4 ☐ Pregnant at  9 ☐ Unknown	time of death 5	Other (specify)				Month	Day Yea	ır		
/ Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the u	nderlying cause given in F	Part I.	23e. Did tob	pacco use	e contribute	e to the cause of deat	th?		
Completed by					1 □ Y€	es 2 🗆	No 3□	Probably 4.20nl	known		
plet					24a. Was ar			autopsy findings ava			
Com					autops perform	ned?	death		5 <del>6</del> 01		
Be	25. Was case referred to medical examiner?			Death (Check o	only one)						
<u>ن</u>	1 Inpatie	ent 2 ER/Outpatien y 28b. Time of	t 3 DOA Other: 4 2		ne 5 Reside			pecify)	_		
icate	27. Manner of Death  1	Year) injury	work? M 1 ☐ Yes 2		ou. Describe no	w injury c	occurred				
ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, farm, stre	et, factory, office	28	8f. Location (Str City or Town		Number or	Rural Route Number,			
Salc											
Medical Certificate:	29a. Certifier (Check (Check ny ny n.)) 1 Certifying Physician: To the best of a Medical Examiner: On the basis of examiner on the basis of examiner.	amination and/or investi	igation in my opinion deat	th occurred at th	ne time date and	d place a	and due to th	he cause(s) and manne	er stated.		
2	29b. Signature and title of certifier	cent or thy it connects	29c. License numb					onth, Day, Year)			
	· Ann		RES-0	00	A	CCCCLL	ust s	5 2012			
	30. Name and address of person who completed cause of de	ath (Item 23a) (Type, P				7	4 1	1 / 0:	1000		
te	7	r's Signature	1800 0415	? ona	04 RV14	timo	Te M	aryland 21	281		
te ar	AUG 0 8 2012 Annua	r's Signature									
2011		* **									

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Medical institution, give street and number, **Examiner** 4b. City, Town, or Location of Death County of Death Heal4 George If Unde Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs **Director** 1 🗆 M 2 📭 96 Jash 28a-f show "natural", or items 23a or 28a-f shov adical Examiner must be notified at County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 Mo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral united 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 1 N If Yes, Give Year or Dates 1 Yes 2 W Specify. 3 Divorced Black Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working ife. DO NOT use retired) Elementary/Secondary (0-12) xuminer overn mex Be 17. Father's Name (First, Middle, Last) ည unavailabl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2674 19a. Informant's Name/Relationship (Type, Print) (God daughti Deni Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2612 vonature of Fam. D. Service Livensee 23a. Part 1 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph\_sician/ ocarolia Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine g physician and as the buria-pars Cause (Disease or injury that initiated events resulting in death) Last the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? SUZUNO 2 No 25. Was case referred to medical examiner?

1 \( \sum \) Yes 2 \( \begin{align\*} \text{No} \) Be 26. Place of Death (Check only one) Hospital: 2 Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral a 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 2 🔲 No Investigation Yes 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier

DHMH 17 Rev 06-2011

State

Registrar

AUG 0 9 2012

Rd+216 ROCKVILLE

person who completed cause of death (Item 23a) (Type, Print)

701 Randolph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> <u>012</u> Physician/ July John Rollins Reaves, Jr. 20 2:05 a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Emmitsburg Frederick 402A W. Main Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 15, 1921 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M M 2 🗆 F Months Days Hours Min. 90 205–22–3477 Florida Director Vrs Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Emmitsburg Frederick Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 USA 402A W. Main Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 Married ğ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", white Specify: Completed 3 Divorced 4 Divorced WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Electric Company Self Employed Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Amanda Sjoblom John Rollins Reaves, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 428, Emmitsburg, MD 21727 Betty Reaves, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Elias Lutheran Cem. 7/24/2012 Emmitsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 20a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying, such as cardiac or respiratory arrest, should be not enter the mode of dying. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: fyes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a ld be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? Yes 2 No death? after death.

Director: After this certific in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a)

State

Registrar

31. Date filed (Month, Day, Year)

JUL 2 3 2012

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 2 27196 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 REINITZ August 6:30 A M JANELLE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 417-40-8243 79 1 M 2 XF Sept 14, 1932 Alabama Usual Residence of Deced or 28a-f show 10b. Count 10c. City, Town or Location 0a. State 10d, Inside City Limits Examiner must be notified at Director Frederick Maryland Frederick 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 842 Insley Circle 21701 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. P 2 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: 'natural", If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. d other than " Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ျှ Nanny Pearl Jennins Woodfin B. Cooksey and N 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Leroy L. Reinitz - husband 842 Insley Circle, Frederick, Maryland 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Tremation 3 ☐ Removal from State 8-9-2012 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Marylan d 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) pratron DEUYS Medical **Examiner** endoman Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Doe to for as a conservence on burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for L Day Pregnant at time of death the 1 ☐ Yes 2 2 9 ☐ Unknown detached 9 Unknown cate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate I 2 🗌 No 2 X No 1 Yes Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🕟 No P 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural iniury 5 Pending death. 2 Accident
3 Suicide Investigation filled in by the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) the Hospital hours Medical 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 (Check 3 Certifying Nurse Pre ctitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D43091 8-6-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Ave, Frederick MD 2179 0 Zaidi MO 801 Jacen Tou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RENNO Physician/ Month Year ATRICI М 0315 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death POPLAR SHADY 5178 Anne Arundel If Under 1 Year If Under 24 Hrs
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 220-56-6974 81 Director 1 - M 2 -03/06/1931 Washington DC works permit. Paga 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Marito I Exercitive must be notified at "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Shady Side 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4726 Poplar Road 20764 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, δ Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 🗙o If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: 3 XWidowed 4 ☐ Divorced Completed Specify White Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester J. McGuire Gertrude M. Naphen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Holcomb (daughter) 203 Rod Circle Middletown, MD 21769 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Our Lady of Sorrows 08/06/2012 | West River, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 905 Galesville Rd Galesville, MD 20765 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, LIVER disease or condition resulting in death) CIRRHOSIS Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): ate has baen signad by tha attanding physician and paga 2 should ba datachad for usa as tha burlal-transit Hospital or Attending Physician: Tha law raquiras that tha death cartificata ba axacutad that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year 1 Yes 2 g Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours aftar death,

Funeral Director: Aftar this certificate has I lately filled in by tha funaral director, paga 2 : 1 🗌 Yes 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 | Nursing Home 5 Residence 6 | Other (Specify, မြ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 1 Natural 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0003658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day,

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32. Registrar's Signatur

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State of Maryland / Department of Health and Mental Hygiene

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'n	Dhysisis	/	1. Decedent's Name (First, Middle, Last)	007	incate of D	Catri	2. Date of Dea		2 27 98 3. Time of Death
-	Physicia Medi	cal	Phyllis Elizabeth Roque  4a. Facility Name (if not institution, give street and number)				OS Month	11 Day 201	7
	Examir	ıer		iter	4b. City, Town, or Cumb	irland		A 11800	
	Funeral Director		5. Social Security Number  213-44-9703  Usual Residence of Decedent  6. Sex  1  M 2  F  68	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June		Birthplace (State or Foreign Country) Maryland
	ryland -f shov ed at	ctor		City, Town or Loc	cation				10d. Inside City Limits
	the Mar or 28a e notifi	Dire	Maryland Allegany Fig. 10e. Street and Number 101 Moonlight Drive	rostburg	10f. Zip Code			10g. Citizen of What	1 Yes 2 No
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9800	is filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U Armed Forces? 1 Se 2 No If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Black, W	merican Indian, /hite, etc. <b>White</b>
15-0	72 hou n "natu 1edical	nplet	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa aind of work done du		ng	16b. Kind of Busine	ess/Industry
212	ed within Hygiene. other tha ent, the N		Elementary/Secondary (0-12) 3 College (1-4 or 5+)	Nurse	O NOT use retired)			Health Care	
Maryland 21215-0036	uld be filed Mental Hy narked ott natic even	To Be	17. Father's Name (First, Middle, Last)  Raymond A. Janowitz			18. Mother's Name			
	or not		19a. Informant's Name/Relationship (Type, Print)  Mark Roque  son		g Address (Street ar n <b>and Street</b>		Route Number	; City or Town, State, <b>Marylan</b>	
Baltimore,	permit. Page 1 and 2 si Department of Health a Important: If item 27 is any injury or other tra			Place of Dispos cemetery, crem Cumberlar	sition (Name of natory or other place nd Crematory	e) <b>:</b>	oate st 16, 2012	20c. Location - City  Cumberland	or Town, State  Maryland
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee		Name and Address Durst Funera	,	rost Ave.,	Frostburg, M	D 21532
			23a. Part 1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line.			, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)  a. Due to (or as a consecution of the consecuti	quence of):	2				Onset and Death
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3760	ificate be executed g physician and as the burial-transit		d						
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  23c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
Division of Vital Records, P.O.	ss that the	by Pr	Part II. Other significant conditions contributing to death but not re	CDs.					e to the cause of death?
ords	require been s should	Completed by	extremity ischemia, V	ascul	^ .	bira ha	1 ☐ Y		Probably 4 Unknown autopsy findings available
Rec	Physician: The law this certificate has ral director, page 2	Somp	failure	enseng	102,129	J	autop: perfor	med? prior death	to completion of cause of
ita	sician: certific irector,	Be	25. Was case referred to medical examiner?  Hospital:		Other	ce of Death (Check		2 2 110	
of V	ig Phys ter this neral di	te: To	27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of injury	3 DOA 28c. Injury a work?	4 ☐ Nursing Hor		ence 6 Other (Sp ow injury occurred	pecify)
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D <u>i</u>	tal or A rs after al Direct ed in b		4 Homicide determined 28e. Place of Injury - At h building, etc. (Specification)	fy)	эт, тастогу, опісе		8t. Location (St City or Town	reet and Number or i n, State)	Rural Route Number,
	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director. After this completely filled in by the funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	on and/or investic	aation, in my opinion	<ul> <li>death occurred at :</li> </ul>	he time date an	d place, and due to the	ne cause(s) and manner stated
	To the within To the compl	_	only one) 3 Certifying Nurse Practitioner: To the best of 29b. Signature and title of certifier	^	29c. License r	number	2	e cause(s) and manne 19d. Date signed (Mo	
	5		Mymillshandan M.	<u>, リ</u>	1 200	71867	- 4	3/12/2	012
(	MRS	_	30. Name and address of posson who completed cause of death (Iten  HM IT SUANDAY  31. Date filed (Month, Day, Year)  32. Registrar's Signary		Willow	BROOK	RD,	Cumbre	RIAND, MD
	Stat Registra	6	31. Date filed (Month, Day, Year) AUG 1 3 2012	. Larre					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Henry Robey, Jr. Julv 31 9:28 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Health Nursing & Rehab Ctr Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 1070674918 Mary Land 219-03-9405 93 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits MD Allegany Cumberland 1 X Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 704 White Avenue 21502 USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married 0 δ within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Carman Railroad other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname)
Elise Lovetta 17. Father's Name (First, Middle, Last)
John Henry Robey, Sr. မ Conrad 19a. Informant's Name/Relationship (Type, Print) Robert L. Robey / Son Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 08/04/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) S nature of Funeral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Sour the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician/ CONGESTIVE HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTEXISIO 127 Sequer tially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of): as the bunalattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No for Month Day sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò ATRIAL FLUTTER FIBRILLATION Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

6+

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) AUG 0 1 2012

Lon O

Robustiano J. Barréra,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ande

Jr., M.D.,

32. Registrar's Signature

29c. License numbe

200 Glenn Street, Cumberland, MD

29d. Date signed (Month. Day, Year)

21502

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5, 2012 RUTH CATHERINE RUBY August 10:43 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITA  $\mathbf{L}$ FREDERICK 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 217-46-6975 1 🗆 M 2 🛢 F Aug. 10, 1945 66 Usual Residence of Decedent Maryland 28a-f show at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 11794 Ridgeway Drive 21770 United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Medical Examiner Black, White, etc. ō 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) Hygiene. College (1-4 or 5+) the Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) and Mental His marked o 2 George Balsinger Anna Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is Ruth Ann Manchester, Daughter 5904 Coral Sea Ave., Rockville, Maryland 20851 Baltimore, other 20b. Place of Disposition (Name of cemeter, crematory or other place)
Metropolitan
Crematorium, Inc 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State injury or Department Important: If any injury or once. 4 Donation 5 Other (Specify) Aug.9, 2012 Alexandria, Virginia 22. Name and Address of Facility
Molesworth-Williams, P.A., F
26401 Ridge Road, Damascus, neral Service 21. Signature Funeral Home Maryland 20872 Enter the disease, or complications that caused k, or heart failure. List only one cause on each line at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between Onset and Death Immediate Cause (Final Physician/ PHLMONARY CHRONIC OBSTRUCTIVE disease or condition resulting in death) HEARS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine rany, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burialphysician Physician/Medical Box 68760 the attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 2 No the Unknown 9 Unknown Division of Vital Records, P.O. ò signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 has autopsy certificate | 2 🗌 No Yes 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After this filled in by the funeral di 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation M 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and the Culwell Drive, Mount Airy, Maryland 21771 32. Rigistrar's Signature State ascerd Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 27201 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July Rolens Janice Branzell 30° 2017 12:10P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 803 Severn Avenue Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Min. Hours 215-34-8785 Director 1 □ M 2 🗓 F 76 12/8/1935 Maryland Usual Residence of Decede r than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 803 Severn Avenue 21403 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Microfilm Technician Anne Arundel Co. Schools e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 Is marked other or other treumatic event, 姓 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0sman Henry Branzell Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 Is any injury or other treu Paula Snell/Daughter 2652 Eagles Lake Road, Virginia Beach, VA 23456 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Kalas Crematory or other place, 1 🗀 Burial 2 💢 Cremation 3 🗆 Removal from State 4 Donatj 8/2/2012 Edgewater, Maryland n 5 Other (Specify) 21. Signaturi Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ My cardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physiclan and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 📉 No Month Day Year cate has been signed by the signed by the signed; page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Diabetes Mellitus Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? To the Hospital or Attending Prysruan. ... within 24 hours after death.

To the Funeral Director: After this certificate certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗆 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 N Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 Yes 2 No 2 Accident Investigation М 3 
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 29c. License number 29d, Date signed (Month, Day, Year) D56658 Kaca July 31, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Titus Abraham, M.D. Suite 400 116 Defense Hwy. Annapolis, MD 21401

State Registrar 31. Date filed (Month

AUG 0 1 2012

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ July <sup>Day</sup>2012 30 Margaret Ina Rouse 3:35P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ginger Cove Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min. **Director** 005-10-6719 1 □ M 2 🛣 F 4/13/1915 Maine Usual Residence of Decedent ir then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 🗌 Yes 2 🛣 No Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4000 River Crescent Dr. #4220 21401 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 Prop 1952
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: of Health and Mental Hygiene. Item 27 is marked other then "natural", other traumatic event, the Medical Exar 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Weather Observer Nat'l Weather B<u>ureau</u> Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv.
Important: If item 27 is marken injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Sears Mary Elizabeth Monson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Oleson/Niece 4000 N. Charles St. #302 Baltimore, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Kalas Crematory 4 Donation 5 Other (Specify) 8/1/2012 Edgewater, MD 21. Signatu Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomon Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Dementia disease or condition resulting in death) yrs. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗓 No 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 💹 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: ျပ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D17965 July 31, 2012 30. Name and address person who completed cause of death (Item 23a) (Type, Print) Joseph Friend, M.D. 116 Defense Hwy. Annapolis, MD 21401 31. Date filed (Month Day ) 2012 Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For AMFI State 8/ Registrar HEALTH DEPT. CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anna Belle Roberts July A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 8 Date of Birth Funeral 7. Age (In vrs. last birthday) Days Hours (Month, Day, Year) 220-54-0182 Director 1 □ M 2 🛛 F 62 Yrs May 14, 1950 South Carolina 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 KWes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 318 Pytchley Run Road 21403 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 ☐ Yes 2XXNo If Yes, Give 1 X Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary U.S. Navy 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Eugene Roberts Maria Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brittany Diatz/daughter Friend Page 1 and 2 sl ment of Health a ant: If item 27 is 318 Pytchley Run Road Annapolis, Maryland 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 8/1/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Service/License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician/ UNG CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) Pregnant at time of death ed by the a detached 9 Unknown P.O. s been signed be should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has certificate Yes 2 Division of Vital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) æ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral dire ျှ 1 🗌 Yes Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 29b. Signature and title of sertific 29d. Date signed (Month, Day, Year) 00 064852 2012 ONCOLOGIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2003 Medical Parkway RAVIN ANNAPORIT GNEOLOGY GANL Annapolis, MD 21401

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 01 2012

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Virginia Fay Sproul Ju<sub>1</sub>y 2012 7:45 Р Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Herons Creek Assisted Living North East 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🗓 F Months Days Hours Min. Director 556-22-7658 Arkan<u>sas</u> Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits ital Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗌 Yes 2 🔀 No MD Ceci1 North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Red Toad Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 1 No Specify Specify. 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Taylor Dawson injury or other traumatic Dollie Mae Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicki Krohn – daughter Turkey Point Road, North East, MD 21901 tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of F Important: If ite any injury or ot 8/11/2012 1 ABurial 2 Cremation 3 Removal from State Sacramento Valley Nati. 4 ☐ Donation 5 ☐ Other (Specify) Dixon, California Cem. 21. Signature of Fune al Service Licensee 22. Name and Address of Facility R.T.Foard Funeral Home, PA East Main Street, Elkton, MD 21921 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): e attending physician and ed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) signed by the a 4 ☐ Pregnant g ☐ Unknown a 🗆 Unknowh P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> 2 No 3 Probably 4 Unknown Records, 1 🗆 Yes Completed peen 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? 1 Yes No autopsy After this certificate has page 2 To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 🗌 No Investigation Accident completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31 MD D0062190 241 SHAHNAWAZ KHAN MD TWY, SUITEA, CHESAPEAKE CITY, MD 2191 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vh HERMAN

DHMH 17 Rev 7/2009

State Registrar . Registrar's Signature

			For State	State of M	aryland				and M	lental Hyg	giene	001	^	0 7	005
			Registrar  1. Decedent's Name (First, Middle,	Last	Certificate of Death Reg. No. 2012 27205									205	
н	Physicia			1						2. Date of Dea Month July	Day	$20\overset{Yea}{1}$	r <sub>2</sub>	3. Time of 7:15	
	Medi Examir		Sarah J. Sorbel  4a. Facility Name (if not institution,				4b. City, Town,	or Location	of Death	July		County of De		7.13	A <sup>M</sup>
- Springer			Elkton Care and	l Rehabilita	tion		E1ktc	n				ci1			
	Funeral	Г	5. Social Security Number		e (In yrs. last		If Under 1 Year Months Days	r If Under	24 Hrs. Min.	8. Date of Birti	h	g. E	Birthpla Country	nce (State or	r Foreign
5	Director		213-30-0440 Usual Residence of Decedent	, L. W. Z. E. J.	79	Yrs.				6/25/1	933			MD	
	and show	ğ	10a. State 10b. County		10c. City,	Town or Loc	ation						100	d. Inside Cit	ty Limits
	Maryl 28a-f otifie	Director	MD Cecil		Ris	ing Su	ın							1 🗌 Yes	2 🛚 No
	h the sa or be n	믈	10e. Street and Number			_	10f. Zip Code				10g. Citize	en of What	Countr	y?	
	th wit	Funeral	4 Meadow Court	Tro W. B. Jan		40.14	21911				US.				
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status  1    Never Married 2   Marri  3   Widowed 4   Divorced	12. Was Decedent E Armed Forces? 1  Yes 2 X If Yes, Give Year or Dates.		If	Vas Decedent of Yes, specify Cu ☐ Yes 2 🔀 N	ban, Mexicar	n, Puerto F	city Yes or No- Rican, etc.)		4. Race - Ar Black, Wi pec <i>ify:</i>		c.	
2-0	2 hou "natu dical	blet	15. Decedent (Specify only highes				ent's Usual Occi ind of work done		t of working	ng.	16b. Kind	d of Busines	ss Indu	stry	
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lary	should and N is ma		19a. Informant's Name/Relationshi	ip (Type, Print)		19b. Mailin	g Address (Stree	et and Numbe	er or Rural	Route Number	City or To	own, State,	Zip Co	de)	
	nd 2 s ealth m 27		Josephine Sorbe	ello - siste	r	4 Mea	adow Cou	rt, R	ising	Sun, N	1D 21	911			
ore	ge 1a it of H if ite or oth		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation	3 Removal from State	cen	netery, crem	sition (Name of atory or other pl			ate	20c. Loca	ation - City	or Towi	n, State	
Baltimore,	it. Pag irtmen irtant: njury		4 Donation 5 Other (Sc		Ho1y		emer Cen					timor			
Ba	permit Depar Impor any in		21. Signature of Funeral Service Lic	7. Good	lie	1	Name and Add	ueen S	St.,	Rising	Sun,			-	•
	Phymician/		23a. Part 1 Enter the disease or c shock, or heart failure. List or Immediate Cause (Final disease or condition	complications that caused aly one cause on each line			r the mode of dy lamoma		cardiac or	respiratory arm	est,		Ir C	Approximate nterval Betv Onset and D	ween Death
	Medical Examiner		resulting in death)	Due to (or as a	a consequer	nce of):							un	KAND	<b>~</b>
	ed nsit	Examiner	Sequentially list conditions, if any, medical translations cause. Enter Underlying Cause (Disease or linjury												
	icate be executed physician and is the burial-transit	al Exa	that initiated events resulting in death) Last	C. Due to (or as a	a consequer	nce of):									
760	cate b physi s the b	edical	<u> </u>	d							-		$\perp$		
89	oertifi ending use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectonic pregna	nov			23	3d. Date of o	delivery	,	
P.O. Box 687	the death by the attr ached for	hysici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at g Unknown			Other (specify)	TICY				Month	Da	ay Y	ear
ds, P.(	quires that en signed ould be der	ted by	Part II. Other significant condition	is contributing to death b	out not result	ing in the ur	nderlying cause	given in Part	l. 			contribute		_	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M								24a. Was a autop perfor 1 \sum Yes	sy med?	death'	o comp	oletion of ca	
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<u> </u>	Physic this cral dir	2	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatie	ent 2 EF	R/Outpatient Bb. Time of	3 🗆 DOA 01			ne 5 Reside			ecify)		
ion o	ttending death. stor. After the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigs 3 Suicide 6 Could n	(Month, Day	/, Year)	injury	M 1 E	rk? Yes 2	No	8d. Describe ho					
<u>N</u>	oital or A urs after eral Direc illed in by		4 ☐ Homicide determin	building, etc	c. (Specify)					8f. Location (Si City or Town	n, State)			oute Numbe	эг,
	the Hosp hin 24 ho the Fune mpleted f	Medical	(Check 2 Medical Ex only one) 3 Certifying I	Physician: To the best of caminer: On the basis of ex Nurse Practioner: To the	xamination a	nd/or investi	gation, in my opir eath occurred at	nion, death oc the time, date	ccurred at t	the time, date are, and due to the	d place, ar cause(s) a	nd due to th ind manner a	e cause as state	ed.	ner stated.
	\$ \$ \$ \$ \$		29b. Signature and title of Continer  Geh	der-S. MD			29c. Licen	se number 8 <i>23</i> 32	2	2	29d. Date s	7. <b>23</b> .			
			30. Name and address of person w	vMD, 12	64	Eth	int)	EQ,	klon	m) 21	921.				
	Stat Registra		31. Date filed (Month, Day, Year)	3 0 1 2012 Registra	ar's Signature	• • A.	back								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Gladys Carson Sentman 2012 Jul.v 30 7:00 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Harford 102 Bayland Drive, Unit No. 7 Havre de Grace 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 217-07-0955 1 M 2 F June, 22 Year 1917 95 Maryland Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10a State 10d. Inside City Limits Director Maryland Havre de Grace Harford 1 ☐ Yes 2 ▼ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 102 Bayland Drive, Unit No. 21078 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3X Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Perry Point other than Elementary/Seconday (0-12) College (1-4 or 5+) Twelve Years Kindergarten Teacher Maryland permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Carson Millicent Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4930 Hogback Road, Fowlerville, Michigan (Daughter) JoAnn Hague 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 08/03/12 Port Deposit, Maryland Hopewell Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. homas Perryville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li retail Co.
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year 1 ☐ Yes 2 t 9 ☐ Unknown signed by t An II. Other significant conditions contributing to that hot not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has t page 2 sl autopsy death? within 24 hours after deam.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: No Ita Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

Year

29b. Signature and title of certifier

31. Date filed (Month. Day.

of person who completed cause of death (Item 23e) (Type, Print) 25

29d. Datersigned Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:55 A 2019 Α. STIFFLER August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6178 S. Steamboat Way New Market Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days (Month, Day, Year) Director 168-34-6684 1 X M 2 □ F Yrs. 71 11/19/1940 PA Usual Residence of Decedent 27 is marked other than "naturel", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6178 S. Steamboat Way 21774 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give Completed 3 Divorced Specify: Year or Dates. 1963-65 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) technician Lucent Technology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Hitem 27 is marked of မ Harry Arthur Stiffler Lilias E. Neely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Mandy Stiffler/wife 6178 S. Steamboat Way, New Market, MD 21774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit, Page 1 a
Department of F
Important: If ite
any Injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 Ø Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/07/2012 Stauffer Crematory Frederick, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, such as cardiac or respiratory arrest, shock, or heart the mode of dying, shock are the mode of dying are the mode of dying. Approximate Interval Between Onset and Death CARCINOID Immediate Cause (Final disease or condition Physician/ MWTHS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has rail director, page 2: autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) ᅙ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phy within 24 hours after death, To the Funerel Director: After thi completely filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 28d. Describe how injury occurred 1/25 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1XX 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M. O'CONNOR 501 W, SEVENTH ST. FREAERICK ND 21701 MO 31. Date filed (Month, Day, Year)
AUG U 9 ZUIZ 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registra

Box 68760

Records, P.O.

Division of Vital

Darke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Ye Walter Wesley Sawyer III August 11:05 p.Mn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 44600 Tall Timbers Road St. Mary's Tall Timbers Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Hours 191-34-3464 **Director** 1 **X** M 2 □ F Usual Residence of Decedent 68 04/24/1944 Maryland 28a-f show at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 X No Maryland St. Mary's Tall Timbers 20 10e. Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 44600 Tall Timbers Road 20690 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ♣ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 ρ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Law other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental E 2 Walter W. Sawyer Miriam S. Sherlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 Margaret C. Sawyer/Wife 44600 Tall Timbers Road, Tall Timbers, MD 20690 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ₽ 9 1 Burial 2 XCremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 08/15/2012 Charlotte Hall, MD Signature of Funeral Savice License Kathleen Santivasci 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00872 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Phyllician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consultation of Exami and resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year the Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page perform this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Tyes 은 1 Inpatient 2 ER/Outpatient 3 DOA Manger of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? within 24 hours after death.

To the Funeral Director: A completely filled in by the fi М 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar

State

AUG 1 5 2012

(Check

only one) 29b. Signature and title of

30. Name and address of

31. Date filed (Month, Day, Year)

Jennifer Schmidt, D.O. 40900 Merchants Lane, Suite 205, Leonardtown, MD

son who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H005575

20650

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GEORGE THOMAS SHRECK AUGUST 2012 4:15 av Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 21256 Haven Rd. Rock Hall Kent 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours **Director** 215-26-4949 Jan 28 1933 79 Maryland 1 🕅 M 2 🗆 F ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City. Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Kent Rock Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21256 Haven Rd. 21661 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☒ Yes 2 ☐ No þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 al Hygiene. If Yes, Give Year or Dates. **Korean** 1 ☐ Yes 2X No Specify White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) should be filed with and Mental Hygien 7 is marked other tl Mail Room Clerk Private College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alvin Shreck Mary Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Anthony G. Younger (nephew) P.O. Box 494 Rock Hall, MD. 21661 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cremation 3 ☐ Removal from State St. John's Cemetery 8/18/12 Rock Hall, MD. 4 Donation 5 Other (Specify ra Service 21. Sign 22. Name and Address of Facility Galena Funeral Home of Stephen L. Sch 118 West Cross St. Galena, MD. 21635 M00510 he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, art failure. List only one cause on each line. Approximate Interval Between shock, or he Immediate Cause (Final disease or addition Onset and Death Physician End Stag who Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by D CHE DHEN @ ASHD 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes Accident Investigation 24 hours after deat Funeral Director, 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

Kin Kue Wun, M.D. 415 Washington Ave. 31. Date filed (Month, Day, Year) AUG 2 4 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Ill allem

32. Registrar's Signature

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

72/3/3

Chestertown, MD. 21620

8/14/12

			State	partment of Health and Me ertificate of Death	ental Hygiene	0 07010								
			1. Decedent's Name (First, Middle, Last)		Reg. No. 2	3. Time of Death								
	Physicia Medi		Florence M. Stewart		August 5, 2012									
-	Examir	ier	4a. Facility Name (if not institution, give street and number)  Fox Chase Nursing	4b. City, Town, or Location of Death Silver Spring	4c. County of Do	4c. County of Death  Montgomery								
	Funeral Director		5. Social Security Number 253-20-4337 6. Sex 1 □ M 2 🕱 F 7. Age (In yrs. last birthda 89 yrs			Birthplace (State or Foreign Country) Georgia								
	nd how at	'n	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits								
	Maryla 28a-f s otified	Director	DC N/A	Washington		1 🛣 Yes 2 🗆 No								
	with the is 23a or nust be n	Funeral D		10f. Zip Code <b>20017</b>	10g. Citizen of What United S	Country? States								
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	1 Never Married 2 Married 1 Yes 2 No	3. Was Decedent of Hispanic Origin? (Specil If Yes, specify Cuban, Mexican, Puerto Ri  1 Yes 2  No Specify:  1	can, etc.) Black, WI	nerican Indian, hite, etc. frican merican								
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Maryland 2	d be filed w Aental Hygi irked other ric event, i	To Be	17. Father's Name (First, Middle, Last) Evans Smalls											
	nd 2 should be file salth and Mental F n 27 is marked o er traumatic eve			iling Address (Street and Number or Rural F Plank Road, Dillwyn		Zip Code)								
Baltimore,	Page 1 arment of He tant: If iter		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, ca	position (Name of ematory or other place)  Heaven Cem.		or Town, State								
Ball	permit Depart Import any inj		21. Signature of Funeral Service Licenses  22. Name and Address of Facility McGuire Funeral Service Character Communications of Facility McGuire Funeral Service Character Ch											
	Pnysician Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Lung Metastasis  resulting in death)	nter the mode of dying, such as cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death 3 months								
	Examiner		Renal Cell Cancer	5		6 months								
	р <b>1</b>	Examiner	Sequentially list conditions, if any, leading to immediate nous Energy Sequence of Due to (or as a consequence of):  Cause (Disease or injury)											
	icate be executed a physician and is the burial.		that initiated events resulting in death) Last C. Due to (or as a consequence of):											
09	ate be ohysicii the bu	edical	d											
. Box 687	death certii ne attending ed for use a	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 12 No 9 □ Unknown   23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 1 □ Yes 2 12 No 9 □ Unknown   25c. No 9	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of a Month	delivery Day Year								
s, P.O.	s tha gned	ρ	Part II. Other significant conditions contributing to death but not resulting in the Anemia	underlying cause given in Part I.	23e. Did tobacco use contribute									
örd	w requisible been 2 shoul	Completed	Malnutrition		24a. Was an 24b. Were a	autopsy findings available								
Vital Records,	The ate h		Chronic Heart Disease		performed?death?	completion of cause of es 2 No								
/ita	rsician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 X No  Hospital:  1  Inpatient 2  ER/Outpat	26. Place of Death (Check or		,								
101	ing Phy (fter thi uneral o		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 1 ☑ Natural 5 ☐ Pending (Month, Day, Year)		<ul> <li>5 ☐ Residence 6 ☐ Other (Special)</li> <li>Describe how injury occurred</li> </ul>	ecify)								
Division of	Attend r death ctor: A	Certificate:	2 Accident Investigation 3 Sulcide 6 Could not be	M 1 Ves 2 No	f. Location (Street and Number or R	ural Route Number								
N	vital or urs afte ral Dire		building, etc. (Specify)		City or Town, State)									
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifler  1	stigation, in my opinion, death occurred at the death occurred at the time, date and place, a	e time, date and place, and due to the and due to the cause(s) and manner a	e cause(s) and manner stated. as stated.								
D			29b. Signature and title of certifier 7. Brull A	29c. License number D35055	29d. Date signed (Mon August 6,									
			30. Name and address of person who completed cause of death (Item 23a) (Type Jose F. Bonelli, M.D.; 8807 Colesvil	Print) e Rd., 2nd Fl., Silver	Spring, Maryland	1 20910								
	Stat Registra	e r	31. Date filed (Month, Day, Year)  AUG 0 8 2012  Length J. Hegistrar's Signature  J. March J.	KI.										

			For State Registrar	State of Ma	ırylan		artment of I			giene Reg. No. 201	2 27211
н	Physicia	an/	1. Decedent's Name (First, Middle, La	ast)					2. Date of De	ath	3. Time of Death
ale to Standard	Medi	cal	Rudy R. Shockey						Month Au	gust 05, 2012 Yea	11:20 AM M
	Examir	ier	4a. Facility Name (if not institution, giv	e street and number)			4b. City, Town, o			4c. County of De	eath
4.27	Funeral		1639 Finzel Road  5. Social Security Number 6.	Sex 7. Age	(In vrs. la	st birthday)	If Under 1 Year	Frostburg		Allegany	District Court of
	Director			1 <b>X</b> M 2 □ F	67	Yrs.	Months Days	Hours Mi	n. (Month, Da	y, Year) (	Birthplace (State or Foreign Country) Marvland
	d d	L	Usual Residence of Decedent  10a. State 10b. County							12.17-17	natylatiti
	arylan a-fsh fied a	cto		1		, Town or Lo	cation				10d. Inside City Limits
	or 28	ä	Maryland Allega  10e. Street and Number		FIC	stburg	10f. Zip Code			10g. Citizen of What (	1 Yes 2 No
	with t	Funeral Director	1639 Fi	nzel Road			21532-			U.S.A.	Sountry?
	death items items		11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S	. 13. V	Vas Decedent of H	ispanic Origin? (	Specify Yes or No-		nerican Indian,
36	after I", or kamir	d by	1 Never Married 2 Married	1 Yes 2 N			Yes, specify Cuba		nto Hican, etc.)	Black, Wh	nite, etc.
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p	be flied within 72 hours after death with the Maryland and Hygiene. Red other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho cevent, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle,		
3	should be file and Mental I is marked o raumatic eve	-	Roy Shockey	_				Effie L.			
Maryland 21215-0036	I and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.  The strand Mental Hygiene.  The strand of the trans "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (1							; City or Town, State, 2	
<u>ق</u>	l and 2 s f Health item 27 other tra		Sandy Shockey  20a. Method of Disposition	Wife	20b. Pla		nzel Road sition (Name of	F <sub>1</sub>	rostburg Date	Maryland	
Baltimore,	a = = =		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		се	metery, crem	catory or other place			20c. Location - City of	
a E	permit. Pag Department Important; any injury c		21. Signature of Fundal Service Licen			-	Name and Addres		igust 08, 2012	Frostburg	Maryland
m	Pe II D	- 1	Muholes Y	Derol		1/			7 Frost Ave.,	Frostburg, MI	21532
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the cause on each line.	ne death.						Approximate
- P	h sician/	0 1	Immediate Cause (Final disease or condition	Renal C.	ell	Car	rev				Interval Between Onset and Death
new.	Medical Examiner		resulting in death)	Due to (or as a c	onseque	ence of):					2 years
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	0000000	222.20					
Pa.	nsit	Examiner	Cause (Disease or linjury	Due to (or as a c	onseque	ence ot):					
<b>J</b>	in and	Exe	that initiated events resulting in death) Last	Due to (or as a c	onseque	ence of):					
00	physician and the burial-transit	dical		l d							
08/p(	ing ph	Me	IF FEMALE;								1
X	h. After this cartificate has been signed by the attending ph funeral director, page 2 should be detached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live Birth 2	Fetal	death 3 🔲		у		23d, Date of d	
. Box	the a	iysic	1 Yes 2 No	4 ☐ Pregnant at ti 9 ☐ Unknown	me of de	ath 5 ∐	Other (specify)			Month	Day Year
ָ ׆ ֖֖֖֖֖֖֖֖֖֖֖֖֖֖֖֓	ed by detac	by Ph	Part II, Other significant conditions c	ontributing to death but	not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did to	pacco use contribute t	to the cause of death?
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VITAI   vsician:	ctor, p		25. Was case referred to medical examiner?				26. Pla	ace of Death (Che	1 Yes	Z NO IL YE	es 2 No
T V	this ca	ျှ	1 ☐ Yes 2 🗷 No	Hospital: 1  Inpatient			3 DOA Othe	r: 4  Nursing I	Home 5 Reside	ence 6 Other (Spe	cify)
n OT	h. After funer	Certificate:	27. Manner of Death  1 ★ Natural 5 □ Pending	28a. Date of injury (Month, Day, Y	ear) 2	8b. Time of injury	28c. Injury work?	? _	28d. Describe ho	w injury occurred	
VISION or Attendir	deat ctor: y the	≝	2 Accident Investigation 3 Suicide 6 Could not b		- At hom	e form etro		Yes 2 ☐ No	001  1' (0)		
	after Dire		4 Homicide determined	building, etc. (\$	Specify)	e, iaiii, siiee	et, ractory, office		City or Town	reet and Number or Ru , State)	ural Route Number,
■ ospita	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for its properties.	Medical	29a. Certifier 1 Certifying Phys	sician: To the best of my	knowled	dge, death oc	cured at the time,	date and place,	and due to the caus	se(s) and manner as st	ated.
the H	nin 24 the Fi		only one) 3 Certifying Nurs	ner: On the basis of example Practioner: To the best	nination a	ind/or investig	iation in my opinior	a death accurred	at the time date an	d place and due to the	nouses/e) and manner stated
P			29b. Signature and title of certifier	00.			29c. License		2	9d. Date signed (Mont	h, Day, Year)
•	3A	-					000	33325		Aug 06,2	012
/	MRS		30. Name and address of person who o	MD 925	Bis	hop V	valsh R	Rd Cur	nberland	Aug 06,2 1 MD2150	2
	State Registra	r	B1. Date filed (Month, Day, Year) AUG 0 7 20	32. Pégistrar's	Signatur	i. Spa	isted				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Terry Shelley 2012 Dennis Medical 12:00 AM 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8 Chesapeake Mobile Court Hanover Anne Arundel Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Min Director 220\_58\_0811 Usual Residence of Decedent 1 X M 2 □ F Jan 31, 1955 MD 57 ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Hanover 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Chesapeake Mobile Court 21113 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", If Yes, Give Year or Dates 1 Yes 2 Xo 3 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Purchasing Director Hospitality Mgt. Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert E. Shelley Eleanor Mae Grapes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert Shelley II 609 Crawfords Ridge Road brother MD 21113 Odenton 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Davis Memorial Cemetery** 8/10/201 MD Cumberland 21. Sonatur of Funeral Se vice Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician, Onset and Death Cardiac Medical resulting in death) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last A120 Morbid Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Day Year the funeral director, page 2 should be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mad MSO Pacemaker Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? has After this certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Tes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the f 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying flurse ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29c. License number 8/06/2012 completed cause of death (Item 23a) (Type, Print) mrs. Little Patuxent PKW Hamid Ehsani 31. Date filed (Month, Day, Year) State 32. Registrar's Signature AUG 09 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edna Pearl Sferra 10:13 A M 2012 August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Devlin Manor Health Care Center Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** Months Days Hours 1 🗆 M 2 💢 09717771934 217-28-9683 77 Maryland **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No MD Allegany Cumberland 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral USA 10301 Christie Road, NE 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 10 · 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 💢 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) f Health and Mental Hygiene. Item 27 is marked other tha Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname, Edna Pearl Robe: 17. Father's Name (First, Middle, Last) Robertson မ Ralston Edward John 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Joyn, State, Zip Code)
Route 1 Box 451, Ridgeley, WV 26753 Ronney T. Ralston / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 K Cremation 3 Removal from State Cumberland Crematory 08/06/2012 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. f Funeral Service Signature 21502 404 Decatur Street, Cumberland, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1, Enter the disea Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final .Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed eral Director; After this certificate has been s filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 🗶 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 2 - No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 No hours after death 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral I Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title August 6, 2012 D17565

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of

31. Date filed (No.

Anthony J. Bollino,

32. Registrar's Signature

rson who completed cause of death (Item 23a) (Type, Print) • Bollino, Jr., M.D., 922 National Highway, LaVale, MD

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Physician/ Day 07 Hubert Ray Stanley Sr. 8:31 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1813 Buck Harbor Ct. Pocomoke City Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 SC 1 🌠 M 2 🗆 F Months 247-42-1217 81 12 - 22 - 1'93'0 **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Worcester Pocomoke City 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1813 Buck Harbor Ct. 21851 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 No
If Yes, Give
Year or Dates 52-56 1 ☐ Yes 2 ▼ No Specify: 3 Widowed 4 Divorced Completed Specify: White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked o ည Lawrence M. Stanley Irene Cato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other trau Margaret J. Stanley/Wife 1813 Buck Harbor Ct., Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Salem United Meth. Cem. 8/11/12 4 Donation 5 Other (Specify) Pocomoke City, MD 21. Signature of Fundral Service Licenses 22. Name and Address of Facility Holloway Funeral Home P.A. 107 Vine St., Pocomoke City, MD, 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph\_sician/ Onset and Death TastatiL disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes Yes Be director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 3 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of ath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accider 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 completed filled in by the funeral 24 hours

Baltimore, Maryland 21215-0036

DAN 6+1

State Registrar

only one)

W DUALL

COASTAL

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:35 A Augus t Physician/ Pauline Margaret Staley 2012  $A_{M}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Northampton Manor If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Min. Jan. Z, Year 918 Months Days Hours Mary Pand 217-10-0656 Director 1 □ M 2 🕅 F Yrs. th and Mental Hygiene. 27 is marked other then "netural", or items 23e or 28a-f shov treumetic event, the Medical Examinar mutable natived at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Frederick 1 Yes 2 No MD Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21701 United States 244 Dill Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 end 2 should be filec Department of Health and Mental H Importent: If Item 27 Is marked of eny Injury or other treumetic even Porse. Margaret Esterly Lester H. Fogle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8945 Indian Springs Rd., Frederick, MD 21702 Judy Cromwell (Personal Rep.) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mount Olivet Cem 20a. Method of Disposition 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State 8/14/2012 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Reeney & Basford P.A. 106 E. Church Street, Funeral Home Frederick, MD 21701 MO1612 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ ulmonary Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner as a consequence of) signed by the attending physician and id be detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by aute dements a 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physicien: The law require within 24 hours after death.

To the Funderel Director, After this certificate has been si completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 1 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation 6 ☐ Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) Monte Sued W 00 22. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene For State Registrar 27216 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 Physician/ August Claude Wayne Stone 2012 5:55 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 219-46-2221 Director 1 X M 2 🗆 F 65 January 31, 1947 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f s Maryland Frederick Brunswick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ must be Funeral 23a 921 East C Street 21716 United States of America permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traums\*\*\* 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) General Laborer General Labor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Earl Kenderson Stone Evelyn Virginia Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Catherine Stone / Wife 921 East C Street, Brunswick, Maryland 21716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) August 11, 20c. Location - City or Town, State 1 🗆 Burial 2 🏿 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory **Ž012** Smithsburg, Maryland Signature of Funeral Service License 22. Name and Address of Pacility Keeney & Bastord P.A. Funeral Home MO1433 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Lung cancer Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Pulmurary Disease physician and s the burial-trans that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy Hospital or Attending Physician: The L24 hours after death.
Funeral Director: After this certificate h 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: မ 1 Yes 2 100 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier August 6, 2012 D0073197 s of person who completed cause of death (Item 23a) (Type, Print) Y Kajal S. Roy M.D. 7th Street Frederick, MO21701 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 27217 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Ann Sommerman Lacy July 2012 30 3:12P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore University Of Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) **Director** 216-17-7865 1 🗆 M 2 🗓 F 27 9/14/1984 Maryland Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f shown injury or other traumetic event, the Medical Examiner great be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Brunswick 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 325 West Potomac Street 21716 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Not Applicable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ George Henry Sommerman Margaret Ann Diaz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George H. Sommerman/Father 1906 Severn Grove Road, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State Dulaney Valley Mem'1 8/3/2012 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home of Funeral Service License 21. Signate 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death 8 days Physician/ Pulmonary Embolism disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Å Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

☐ Yes 2 🗓 No 1 ☐ Yes 2 ☐ No Be B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🙀 No Certificate: To 1 🔀 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only of 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 7/30/2012 1740546712 30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print) Jesse Kiefer MD22 S. Greene St., Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State AUG 01 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Bartschat Schnebl 8:17 A M AUGU 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 204-03-7648 **Director** 1 - M 2 XF 92 10 07 1919 Danville, PA items 23a or 28a-f show her must be notified at 10a, State 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 622 S. Allison St. 17225 US 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian "natural", or iter dical Examiner Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 5+ teacher public schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental tem 27 is marked o ပ္ Walter Bartschat Naomi Shivley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Schnebly S. Allison St. Greencastle, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date o = 10 1 Burial 2 X Cremation 3 X Removal from State Important: If any injury or Cumberland Valley Crem. 8/17/2012 Waynesboro, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Miller-Bowersox Funeral Home 21. Signature of Funeral Service License 521 S. Washington St. Greencastle, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final nset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-tran been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a conse Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Hospital or Attending Physician: The 24 hours after death.

Funeral Director: After this certificate I 1 Yes 2 No Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No Hospital Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MO.

Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

701

12-06063 Rosalie Silver

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 27219

		1- For State Certificate C	of Death	Reg. No	5. 3. Time of Death				
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)	dent's Name (First, Middle,Last)  2. Date of Death Month						
oudical Exami		Rosalie Silver  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August 13, 20	12 1256 hrs 4c. County of Death				
		9325 Fairhaven Avenue	Upper Mariboro	Prince George's					
Funeral Director			If Under 1 Year If Under 24Hrs Months Days Hours Min.	Months Days Hours Min.					
any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits				
		Maryland Prince George's Upper	Marlboro		1 Yes 2 XXNo				
Maryland 28a-f show d at once.		10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?				
th the 23a or		9325 Fairhaven Ave	20772	anife Van as Na	United States  14. Race - American Indian, Black,				
hours after death with the Maryland 'natural', or items 23a or 28a-f sho Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If	As Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto Yes 2 No specify: Puer	Rican, etc.)	white, etc.  Specify: White				
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	ent's Usual Occupation (Give kind of v	vork done 16b	. Kind of Business/Industry				
7 3 -	etec	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use reti	red)	Own Home				
15-0036 filed within 77 al Hygiene. cd other than t, the Medical	Completed		memaker	(First, Middle, Maide	16.				
<u> </u>	Be C	17. Father's Name (First, Middle, Last)  Gerardo Soto		una Cruz	ourname)				
D 21215 should be fill and Mental H 7 is marked	ToE	19a. Informant's Name/Relationship (Type, Print ) 19b. Maili	ng Address (Street and Number or F	Rural Route Number,	City or Town, State, Zip Code)				
Imore, MD 2 Pages 1 and 2 shoument of Health and I			5 Pinedale Drive Anna	polis, MD 21	.401 Location - City or Town, State				
Ore,		1 Burial 2 X Cremation 3 Removal from State crematory or	other place)						
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Dem Depr		NiA () O Park M00153 1	erry Road, Clinton, M	D 20735					
Physician /Medical		hock, or heart Approximate Interval Between Onset and							
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		Sequentially list conditions, b							
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause							
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Division of Vital Records, ral or Attending Physician: The law require its after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should	To Be	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie			dence 6 🗸 Other: Scene				
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ivisior or Attend after death Director:	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, st		28f. Location (Stree	t and Number or Rural Route Number, City				
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investign.	surred at the time, date and place, and pation, in my opinion, death occurred a	due to the cause(s) at the time, date and p	and manner as stated. place, and due to the cause(s)				
To will	Mec	and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)				
		Patreet Surshall, mi)	O.C.M.E.	Au	ugust 14, 2012				
$\phi$		30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 9	00 W. Baltimore Street, Balti	more MD 2122	3				
9	ate								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August Physician/ 2012 12:30A M Stephen Nathaniel Toms Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Hours 02-15-1925 Maryland **Director** 87 212-28-1287 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 X Yes 2 No Rising Sun Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21911 United States 100 McNamee Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Ballistics Research U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Sadie Pearl Hewitt Albertus Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 664 Biggs Highway, Rising Sun, MD 21911 Elaine Richardson/daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 08-08-2012 Rising Sun, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Foard Funeral Home, Funeral Service Licenses 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final .ongestive Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ATHEROSCI PRANOTO sequentially list recoiling if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires the attending physician and been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Li Fetal Geal Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive Pulmonany 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Yes 2 X 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, it Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Hospital Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signat re and title of certifie 29d. Date signed (Month, Day, Year) 08/06 D0058354 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

101 COLONIAL WAL

M.D.

31. Date filed (Month, Day,

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MD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physician/		shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.		the k	f .				,			Interval	Between nd Death
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l or At after o Direct J in by		4 Homicide determ	pined 28e. Place of	Injury - At ho , etc. (Specif)	ome, farm, stre	et, factory, of	ffice			ocation (S lity or Tow		d Number e)	or Rural	Route Nu	ımber,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		Physician: To the bes Examiner: On the basis												I manner etater
the H thin 24 the Fu mplete	Med		Nurse Practioner: To			leath occurred	at the	time, date and		due to th	e cause(	s) and man	ner as sta	ated.	
<b>5</b> ₩ € 8		296. Signature and title of certifie	Spaller					number 825	-8		4	ite signed (			
12		30. Name and address of person	who completed cause	of death (Iten	n 23a) (Type, P	rint) /	L.	,	, lan		1.00	-2	-		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Alva S Baker	MD 747 1	brther.	n Ave	nue t	Tag	ETSTOW	in MI	1/21	74	*			
Stat Registra		AUG 2 4 2012"	anun "	strar's Signa	Mas										

DHMH 17 Rev 7/2009

Registrar
DHMH 17 Rev 06-2011

State

12520 Prosperity Drive, #150, Silver Spring.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allison Win, MD

31. Date filed (Month, Day, Year) AUG 08 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 048 Dennis Toth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-Regional medical Alleganu amberland 9. Birthplace (State or Foreign Country) S. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Apr 6, 1953 Director 197-46-9543 1 🛛 M 2 🗆 F 59 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director Cambria Sidman 1 Yes 2X No 10e: Street and Number 10f. Zip Code 10g. Citizen of What Country? 15955 136 Leventry Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Bace - American Indian Armed Forces? 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Pet Store Owner Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Helen Hollowniczky Alex Ernest Toth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Reaverdale
PA 19a. Informant's Name/Relationship (Type, Print) 649 Cedar Street 15921 Mary Swope sister Beaverdale 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Dunlo United Methodist Cemetery 8/16/2012 PA Dunlo Donation 5 Other (Specify) ignatur of Funeral Service Lic 22. Name and Address of Facility Albame, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ homowhous disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) sician a burial-Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 N 1 🗌 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural Accident 5 Pending 1 Yes 2 No Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MO 072514 8/12/12

Registrar

DHMH 17 Rev 06-2011

State

Kelly

31. Date filed

RD

Cumberland, nD,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12500

Willowbrook

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 27224 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August anes ron 20 T2 12:54 p.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) Director 215-20-9369 1 ፟M 12 □ F 88 05/03/1924 Maryland 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Walkersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10104 Dublin Road 21793 United States 11. Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Yes 2 No \$ 1 Never Married 2 X Married Black, White etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Auctioneer Trout Auction Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Glenn Trout Mary Reba Haifleigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Trout / wife 10104 Dublin Rd., Walkersville, MD 21793 20a. Method of Disposition
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Stauffer Crematory Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 8/7/2012 Frederick, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee prejulu MO1222 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Mahn ia Ecquentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease injury Due to (or as a consequence of) Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit diaseles that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? 4 Pregnant at time of death
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🕅 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 SYIL 00 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ JULIAN TORTONA 5:55 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BETHESDA, SUBURBAN HOSPITAL MONTGOMERY 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 564-60-7272 Director 77 1 🛛 M 2 🗆 F 1/9/1935 Philippines Usual Residence of Dece 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Brookeville 28a-f Montgomery 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 18637 Tanterra Way 20833 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. P þ 1 Never Married 2 😾 Married 1 Yes If Yes, Give 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. "natural", Completed 3 🗆 Widowed 4 🗆 Divorced Asian Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the Master Chief U.S. Navy Reserved and Mental Hygie is marked other other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Silvestre Cabrera Tortona Felisa 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is, any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Virginia B. Tortona 18637 Tanterra Way, Brookeville, MD 20833 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Cemetĕrv 22. Name and Address of Facility Cole Funeral Services, P.A. 21. Signa re Funeral 4110 Aspen Hill Rd. #100, Rockville MD 20853 23a. Part 1. Enter the disease, or shock, or heart failure. List or rations that caused the death. Do not enter the mode of dying, such as cardiac or rechiratory arrest, cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) INTRACRANIAL Medical Due to (or as a consequence of Examiner 5 DAYS PNEUMONIA Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Exami that initiated events physician ar resulting in death) Last Due to (or as a consequence of 4 Physician/Medical DAYS attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specific 23d. Date of delivery in the past 12 months? detached for Year Pregnant at time of death g Unknown 9 Unknown Pona Judian 08-00 Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by HYPERTENSION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed CARDIAC ARRHYTHMIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Adatural 2 Accident 5 Pending 1 Yes Investigation JYNCOPAL EPISODE 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Numb City or Town, State) determined HOME BROOKEVILLE, MD Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only of 29b. Signat 29d. Date signed (Month, Day, Year) 6/12 D 65234 leted cause of death (Item 23a) (Type, Print) ANAND V. GERMANWALA

Registrar

DHMH 17 Rev 06-2011

State

N. WOLFE

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2012

back

BALTIMORE, MD

MEYER 8-181,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Joseph Alexand	51 C	1- For State Ragistrar	te of Maryland / Depa <i>Ce</i>	artment of <i>rtificate of</i>		nd Mental		Reg. No.	201	2 27	22
Physicia Medical Exami		Decedent's Name (First, Middle,  Joseph	Alexander		Ulrich	Jr.	2. Date of De Month August 1	eath Dav	Year	3. Time of Dea 1102 hrs	
		4a. Facility Name (if not institution, Johns Hopkins Hospita		4	b. City, Town, o	or Location of De			County of Dea		
Funeral Director			Sex 7. Age (In yrs. X M 2 F 40	last birthday) Yrs.	If Under 1 Ye		Ars. 8. Date of B		D/YYYY) 9. B Fore	irthplace (State or	
d 20w any		Usual Residence of Decedent  10a. State 10b. County  MD N/A		, Town or Location	on					10d. Inside City	y Limits
ne Maryland or 28a-f show ified at once.	Director	10e. Street and Number 917 N. Calvert		timore	10f. Zip Code				en of What Cou		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatite event, the Medical Examiner must be notified at once.	Funeral I	11. Marital Status 1 X Never Married 2 Marr	12. Was Decedent Ever in U Armed Forces?  1 Yes 2 X No	If Ye	es, specify Cuba	n, Mexican, Pue	Specify Yes or Norto Rican, etc.)	10- 1	White, etc.	rican Indian, Blac	k,
6 72 hours afte in "natural"	leted by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	red If Yes, Give Year or Dates: v only highest grade completed) College (1-4 or 5+)	16a. Decedent		o specify: ation (Give kind o e. DO NOT use r			pecify: What and of Business.	iite /Industry	
15-0036 filed within I Hygiene. ed other tha	e Completed	17. Father's Name (First, Middle, L.	•		QMRP		me (First, Middle	Maiden S	,	rvices	
AD 212: 2 should be h and Menta 27 is marke matic event	To Be	Joseph Alexande  19a. Informant's Name/Relationship  Joseph A. Ulrich	(Type, Print)			et and Number o	rances B or Rural Route Nu thsburg,	mber, City		e, Zip Code)	
more, Pages 1 and ent of Healt int: If item		20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other Spec	3 Removal from State	Place of Disposit crematory or oth	tion (Name of ce er place)	emetery,	Date 17/2012	20c. Lo	ithsbur		
		21. Signature of Funeral Service Lie  5. Mark  5	ensee	22. Na 160	ame and Addres	s of Facility R	est Have	n Fur	neral C	hape1	42
Physician /Medical Examiner		23a. Part I. Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)		the Chest a			or respiratory a	rest, shock	k, or heart	Approximate I Between Ons Death	et and
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b.  Due to (or as a consequence of c.								
t <b>0,</b> e be executed ysician and burial - transit	edical Examiner	events resulting in death) Last	Due to (or as a consequence of d	f):							
	ΣI	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkno	23c. If yes, outcome of preging 1 Live birth 4 Pregnant at time of de	2 Feta	al death 3 er (Specify)	Ectopic pregi	nancy		Date of deliver	y Day Yea	ar
i, P.O. B ires that the de signed by the I be detached f	ত্র	Part II. Othar significant condition	s contributing to death but not re	esulting in the un	nderlying cause	given in Part I.				the cause of deal	
Division of Vital Records, P ral or Attending Physician: The law requires the ster death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be death.	Completed									utopsy findings av completion of causes 2 1	
Vital Rechysician: The this certificate	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ✓ Inpatient 2	ER/Outpatient		of Death (Chec	k only one) sing Home 5	Residenc	e 6 Othe	r.	
ion of tending Ph leath.	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investig		28b. Time of Inj 0347 hrs		ry at Work? Yes 2 ✔ No	28d. Describe Subject was		occurred		
£ 6 0 5.	Certification:	3 Suicide 6 Could n 4 Homicide determin	28e. Place of Injury - At ho led (Specify) Local Stree	et			9 E. Chase S	State) treet, Bal	timore, MD	ral Route Numbe	r, City
Div To the Hospital or within 24 hours afte To the Funeral Dii Completely filled in	edica	(Check only	ician: To the best of my knowledger: On the basis of examination are and manner stated			, death occurred		and place		e cause(s)	
		Paysety Withell, 30. Name and address of person wh	O completed cause of death (Hem	23a)	O.C.				st 11, 2012		
JW-8		Pamela E. Southall, MD	Assistant Medical Exar	miner 900		e Street, Bal	timore, MD 2	1223			
Sta Registi	ar	31. Date filed (Month, Day Year)	3012 32. Rigistrar's Signatul	1. pa	A. S.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan					201	2 2722
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeatri	2. Date of De	Reg. No. 201	3. Time of Death
	Physicia Medic		Vitoria Lourenco	Vieria				a Month	3 ZC/2	10254M
0	Examin		4a. Facility Name (if not institution, give str Baltimore Washingto		r		Location of Death Burnie		4c. County of Dea	Arundel
	Funeral Director		5. Social Security Number 6. Sex $099-46-3234$ 1 $\square$	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da		ortugal
	show d at	tor	Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Loc			1 -		10d. Inside City Limits
	e Mary r 28a-f notifie	Director	MD Anne Aru	ndel		Gambr 10f. Zip Code	ills		10.000	1 🗆 Yes 2 No
	s 23a o	Funeral	2123 Autumn Haze	Court			1054		10g. Citizen of What C	ountry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 Married  3 WWidowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		/as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	
Vخلص Maryland 21215-0036	ithin 72 hou ene. r <b>than "natu</b> <b>the Medical</b>	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give k life. DC	ent's Usual Occup ind of work done of NOT use retired) nemaker	ation during most of worl	ring	16b. Kind of Business	Mome
Vitoral	d be filed w fental Hygi rked other tic event, t	امها	17. Father's Name (First, Middle, Last)  Jouquin Lourenco		11011			ne (First, Middle, ria Cond	Maiden Surname) Ceicao	
Ver Mary	d 2 should alth and M 27 is ma er trauma		19a. Informant's Name/Relationship (Type Antonio Jesus Lour	. 2011					r, City or Town, State, Z brills, MD	
VieteA, Baltimore,	Page 1 an nent of He ant: If item ary or othe		20a. Method of Disposition  1 X Burial 2 Cremation 3 Received A Company Compan	20b. P	lace of Dispos	ition (Name of EPISCOPE		Date	20c. Location - City o	r Town, State
Vie Balti	permit. Departr Importa any inji		1. Signature of Furieral Service Literate	MO box	22.	Name and Addres	ss of Facility Be	all Fune	eral Home , <b>Mary</b> land	
	Hysterna/		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.		the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence Compartne	ence of):	Sunda	cm 0			
	ted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		4.100	31. 4			
09	ate be executed hysician and the burial-transit	dical Ex	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
928	rtificati ing ph	/Med	F FEMALE:							
. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Me	236. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3 🗌	Ectopic pregnand Other (specify)	<b>у</b>		23d. Date of do Month	elivery Day Year
ls, P.O.	uires that th n signed by uld be deta	S	Part II. Other significant conditions contr	ributing to death but not resu	ulting in the ur	derlying cause giv	ven in Part I.		obacco use contribute t	o the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law req ate has bee page 2 sho	Completed						24a, Was autor perfo 1  Yes	osy prior to rmed? death?	utopsy findings available completion of cause of
ital	i <b>ician:</b> The certificate rector, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital:		Oth	ace of Death (Chec			
of V	g Phys er this neral di	te: To	27. Manner of Death	1 Inpatient 2 L	ER/Outpatient 28b. Time of injury	3 ∐ DOA 28c. Injun	4 ∐ Nursing H y at		dence 6 Other (Spe ow injury occurred	cify)
ion	ttendin death. stor: Aft y the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No			
Divis	oital or Attencurs after death		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	)			City or Tow		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check 2 Medical Examine)	<ul> <li>an: To the best of my knowler.</li> <li>On the basis of examination</li> <li>Practitioner: To the best of m</li> </ul>	and/or investi	gation, in my opinio death occurred at t	on, death occurred a he time, date and pl	t the time, date a ace, and due to t	nd place, and due to the he cause(s) and manner	cause(s) and manner stated. as stated.
	<b>7</b> 00		Shain Cents	ell Carp	_	29c. License	3413		29d. Date signed (Moni	rh, Day, Year)
			30. Name and address of person who com  30. HCSPITAL  31. Date filed (Month, Day, Year)	Dr Glen	Burr	ne Mi	210	01	Shawn Can	pbell, CNP
	Stat Registra	C	AUG 0 8 20	32. Redistrar's Signat	A. A	new				

	For STA  State Registrar  1. Decedent's Name (First, Middle, Last)	ate of Maryland / Do	epartment of leartificate of L			Reg. No. 2		722
cian/	Elizabeth Wel	sh			2. Date of De Month	Day 27 2	Year	e of Death
niner	4a. Facility Name (if not institution, give street a UniVersity of Mary L			r Location of Death		4c. County		
al or	5. Social Security Number 6. Sex 217-38-3224 Usual Residence of Decedent	7. Age (In yrs. last birthd	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Pa 9 / 1 6 / 1	th y, Year) 940	9. Birthplace (Sta Country) MD	te or Foreigr
neral Director	10a. State 10b. County MD Carroll	10c. City, Town o	r Location inster					e City Limits
Funeral Director	10e. Street and Number 1160 Old Manches	ter Road	10f. Zip Code <b>211</b> 5	57		10g. Citizen of USA	What Country?	
by Fu	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. ned Forces? Yes 2 No ess, Give or Dates.	13. Was Decedent of H If Yes, specify Cuba 1  Yes 2 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Bla	ce - American Indian ack, White, etc. V:White	,
Completed	15. Decedent's Education (Specify only highest grade com	oleted) 16a. D (G lege (1-4 or 5+)	ecedent's Usual Occup live kind of work done o e. DO NOT use retired) amstress	during most of work	J		Business/Industry	
To Be (	17. Father's Name (First, Middle, Last)  Henry Naill	1 56	amscress	18. Mother's Nam		Maiden Surnam		
	19a. Informant's Name/Relationship (Type, Print) Debra Brown - dau		Mailing Address (Street of			-		<del>-</del> .
	20a. Method of Disposition  1   Burial 2 ☐ Cremation 3 ☐ Remov. 4 ☐ Donation 5 ☐ Other (Specify)	al from State cemetery,	isposition (Name of crematory or other place y Cemeter	e) Sy 8/1/	Date 2012		- City or Town, State	
once	21. Signature of Funeral Service Licensee	bornes	22. Name and Addres	s St. We				7
n/ al er	23a Part X Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)		enter the mode of dying Bacter		or respiratory arı	rest,		mate Between nd Death
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	oue to (or as a consequence of):						
Physician/Medical	in the past 12 months?	es, outcome of pregnancy Live Birth 2  Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	y			ate of delivery onth Day	Year
þ	Part II. Other significant conditions contributing	ng to death but not resulting in t	ne underlying cause giv	ren in Part I.			tribute to the cause of	
Completed						rmed?	Were autopsy finding prior to completion of death?	
Be C	25. Was case referred to medical examiner?		26. Pla	ace of Death (Chec		2 🔀 No	1 Yes 2 No	
은	1 Yes 2 No	1 Inpatient 2 ER/Outpa Date of injury 28b. Tim		4 ☐ Nursing Ho		lence 6 🗌 Oth		
Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury  Place of Injury - At home, farm, building, etc. (Specify)	y work		28f. Location (S		ned oer or Rural Route Nu	ımber,
Medical C	(Check 2 \( \subseteq Medical Examiner: On the	the best of my knowledge, dea	vestigation, in my opinic	n, death occurred a	t the time, date a	use(s) and manr	ie to the cause(s) and	manner state
Ž	only one) 3 L Certifying Nurse Practi 29b. Signature and title of certifier	tioner: To the best of my knowled	29c. License			29d. Date signe	manner as stated.  Id (Month, Day, Year)	
	30. Name and address of person who complete	d cause of death (Item 23a) (Typ	e Print)			• ( = .		-

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician/ M VIan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sky Way Manor Annapolis Anne Arunde1 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days (Month, Day, Year, Hours Min Director 212-26-3558 29 Virginia March Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits with the Maryland Director 1 X Yes 2 ☐ No <u>Maryland Anne Arundel</u> Annapolis 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Garden Gate Lane 21403 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: **Black** "natural", 3X Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Anne Arundel 12th Nurse General Hospi Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Williams <u>Alice Green</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederick Simpson (Son) 1800 N. Poplar Ave. Annapolis, Md. 21401 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/10/12 Veteran Ceme. Crownsville. permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Forest Sons Mortuary, Dr. Annapolis, Zan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for es e consequence offi cause. Enter Underlying Cause (Disease or linjury Exami burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atter should be detached for u in the past 12 menths?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Dav Year Unknown Part II. Other significant/conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? performed Z No 1 Yes Yes 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) ted Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Sp. 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of 🗡 ath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature 29d. Date signed (Month. Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed c

31. Date filed (Month, Day, Year) AUG 08 2012 (frem 23a) (Type, Pr

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month Physician/ 2:40 AM Medical 4c. County of Death Examiner zmapile) Anne Arundel Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 578-28-8067 **X** M 2 D F 85 **Director** Nov. 27, 1926 Pennsylvania 28a-f shov at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Odenton MD Anne Arundel 10e. Street and Numbe 10f. Zip Code 0 10g. Citizen of What Country? items 23a Funeral 1010 Samantha Lane # 301 USA 21113 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black White etc. Ь 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify: White Specify. "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Johns Hopkins Applied Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Engineer Physics Lab Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Department of Health and Mont. Important: If item 27 is marked any injury or other. Charles B. Walton Evelyn Spragg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian S. Walton - Wife 1010 Samantha Ln #301, Odenton, MD 21113 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mary Land National | Mem. Park Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Mem. 8-9-2012 Laurel, Maryland 2. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence or, Exami death certificate be executed Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as s, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day the Unknown Hospital or Attending Physician: The law requires that the signed by: Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No After this certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 **N**No မ 1 - Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Detertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar only one)

Name and address

ann

08 2012

29b. Signature and title of certifie

use of death (Item 23a) (Type, Print)

viatim

29d. Date signed (Month, Day, Year) 06

te B, glan Burnie,

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27231 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marjorie ware Month 3:30 P M August 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kris Leigh Assisted Living Davidsonville Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 02/15/1926 Country) Director 414-34-3213 1 🗆 M 2 🛛 F 86 Usual Residence of Deceden permit. Pege 1 end 2 should be filed within 72 hours efter death with the Meryland Depertment of Health end Mentel Hygiene. Importent: If Item 27 is merked other then "neturel", or Iteme 23e or 28e-f show eny injury or other treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Davidsonville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3913 Birdsville Road 21035 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Banking EX. Assistant B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John T. Buntin Evie Hudgens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Furnas Niece 2413 Arapaho Way Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantíc Crematory 08/07/2012 Glen Burnie,MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 851 Annapolis Road Hardesty Funeral Home P.A.Gambrills, MD 21054 Dato 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ Cardiothrombotic Onset and Death Event disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardiovascular Disease Atheroscientric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (ur as a consequence oi). Exami or Attending Physicien: The lew requires that the deeth certificate be executed signed by the ettending physicien end d be detached for use es the burlel-trensif Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours efter deeth.
Funeral Director: After this certificate has etely filled in by the funeral director, page 2. performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗗 No <u>မ</u> 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical To the Hoepi within 24 hou To the Funer completely fi 29a Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number NIRY apareMD D0057465 8/7/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Mo NSRajapakse MD 5203 2835 Smith N

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year) AUG 08 2012

32 Registrar's Signatur

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2012 1:05 P.M Wilson August Marion Hunter Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Hebrew Home of Greater Washington Rockville g. Birthplace (State or Foreign Country) Massachusetts 8. Date of Birth June 8, 1911 If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 1 □ M 2 🖾 F Hours June 214-52-6304 Director 101 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---- any injury or other terms." 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 7008 Sulky Lane 20852 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Yes 2 No δ 1 Never Married 2 Married 1 Yes 2 X No Specify: Specify: 3X Widowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Brockway Ella Archibald Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sulky Lane, Rockville, Maryland 20852 Mary Louise Kidwell/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Post Cemetery 8/15/2012 West Point, New York 22. Name and Address of Facility DeVol Funeral Home ture of Funeral Service Lice 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of) UNIDENTIFIED ORG-ANISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Be Completed

Physician/ Medical **Examiner** 

> attending physician and for use as the burial-transit should be detached signed by the has completed filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

239 St. L. DHE-Breter Division of Vital Records, P.O. Box 68760

in the past 12 months?  1  Yes 2 No 9  Unknown	4 ☐ Pregnant at time of death g ☐ Unknown	5 Other (specify)
art II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part

24b. Were autopsy findings available prior to completion of cause of 24a. Was an

							performed?	death? 1 ☐ Yes 2 ☐ N
25. Was case referred to medical	T		,		26. Place	of Death (Chec	k only one)	
examiner? 1 🗌 Yes 2 No	Ho	spital: 1  lnpatient 2	ER/Outpatient	3 🗆 D	OA Other:	Nursing H	ome 5 Residence 6	Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigati		28a. Date of injury (Month, Day, Year)	28b. Time of injury	М	28c. Injury at work? 1 ☐ Yes		28d. Describe how injury o	
3 ☐ Suicide 6 ☐ Could not	be	OO - Diseasefision At he	ma form atroot	footor	v office		20f Looption (Stroot and I	Jumber or Pural Poute

4 Homicide	e determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check	1 Certifying Physici	an: To the best of my knowledge, death occured at the time, date and place, and the basis of examination and/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and mann

29a. Certifier	1 Certifying Phy	sician: To the	best of my knowled	ige, death occured at the time, date and place, and due to ind/or investig <i>a</i> tion, in my opinion, death occurred <i>a</i> t the time	the cause(s) and manner as stated.  I date and place, and due to the cause(s) and manner st	ated.
(Check only one)	3 Certifying Nu	rse Practioner	: To the best of my k	nowledge, death occurred at the time, date and place, and di	ue to the cause(s) and manner as stated.	
20h Signaturera	nd title of certifier			29c. License number	29d. Date signed (Month, Day, Year)	

290. Date signed (Monta, Day, Teal)

AUGUST 06, 2012

ath (Item 23a) (Type, Print)

M. J. 6121 MANTROSE RD, ROKVILLE MD 20852 26 augus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 08 2012

31. Date filed (Month, Day, Year)

State Registrar

Certificate: To

Medical

within 24 hours after deat To the Funeral Director:

Registrar

State

10+1

Luyuno

Victor Priego, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

32. Registrar's Signature

D23308

#4100

6420 Rockledge Drive, Bethesda, MD 20817

29d. Date signed (Month, Day, Year)

August 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27234 State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0310 John Kenneth Whitney Augus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Salisburg Rehabilitation ellure in Gr. Social Security Number 6. Sex 7. Age (In yrs. last birthday) *Wicomic* Salisburi If Under 1 Year If Under 24 Hr. 8. Date of Birth **Funeral**  Birthplace (State or Foreign Country) Months (Month, Day, Year) Director 212 26 6060 1 🖾 M 2 🗆 F 81 2/22/1931 MD Usual Residence of Deced 28e-f shov 10a. State 10c. City, Town or Location with the Maryland or then "natural", or items 23a or 28e-f sho the Medical Examinar must be multiped at 10d. Inside City Limits Director Worcester MD Ocean City 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13809 Sailing Rd. 21842 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 2 Yes 2 No Black, White, etc. 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Army 1 ☐ Yes 2 🖾 No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and Mental Hygiene, is marked other then College (1-4 or 5+) Liquor Distributors manager traumatic event, Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Gertrude Ward Alvin Whitney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Bernhardine Whitney (wife) 13809 Sailing Rd. Ocean City, MD 21842 Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If ite eny Injury or ot once. 1 Burial 2 Cremation 3 Removal from State First State Crematory 8/9/2012 Millsboro, DE 4 Donation 5 Qther (Specify) 21. Signs in of Fune 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Service Licensee Part 1. Enter the disease, or complications that oau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach ine. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ e we disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical John Whitney Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 Yes 2 9 Unknown cate has been signed by the a page 2 should be detached in 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔟 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 200 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 289 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Transfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sælisbun DH 10+1 Nicholar 150000 200 31. Date filed (Month

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 29<sup>ay</sup> July 2012 Year 10:00 A M Katherine Amato Willard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Hours **Director** 578-62-6681 1 M 2 X F 53 01/26/1959 Washington,DC or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Galesville 1 🗆 Yes 2 💆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4801 Riverside Drive 20765 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: White 3 Widowed 4 TDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CPA **Accounting** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mental H is marked of permit. Page 1 and 2 should be Department of Health end Mem Important: If item 27 is marke eny injury or other treumatic ( once. Robert Amato Evelyn J. McClure 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26270 Daffin Road, Easton, Maryland 21601 Michael Willard/Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 08/02/2012 Silver Spring, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Metastatic Cancer disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and I for use as the burial-translt that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the at Id be detached for 4 🔲 Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Bacterial Peritonitis Records, or Attending Physician: The law requires Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 1 ☐ Yes 2 ☐ No Division of Vital the funeral director. 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 306 ans 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 725 Medical Parkway, Annapolis, MD 21401 0-6: 31. Date filed (Month. 32. Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2 7236

State of Maryland / Department of Health and Mental Hygiene 2 7236

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	Physicia Medic		Sarah Ann Widner				August	11 201	8:00 a M	
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	Funeral		Chestnut Hill Manor Assiste  5. Social Security Number   6. Sex   7. Age	ed Living (In yrs. last birthday		tt City If Under 24 Hrs.	8. Date of Birth	Howar	Cl. Birthplace (State or Foreign	$\exists$
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	arylan a-f sh fied a	cto	MD Howard	10c. City, Town or I	ott City				10d. Inside City Limits 1 ☐ Yes 2 🛣 No	
	he Ma or 28 notii	Ş.	10e. Street and Number	ELLIC	10f. Zip Code	·		10g. Citizen of Wha		4
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	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at		11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13	Was Decedent of H	ispanic Origin? (Spe	ecify Yes or No-	14. Race	American Indian,	┨
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Maryland	e filed Ital Hy ed oth event	To Be	17. Father's Name (First, Middle, Last) Hugo Joseph DeCheubel			18. Mother's Name	e (First, Middle, I h James	Maiden Surname)		
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			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print)	AR LN	4 100	nai	371.18 A 11	٦
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	Funeral Director		5. Social Security Nu 218-72-45	57	6. Sex 1 ☐ M 2 ☐XF	7. Age (Ir	n yrs. last birt 51		Months Days Hours Min. (Month, Day, )				Year) 1960 Pennsylvania			-
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Baltimore, Maryland 21215-0036	be med with the second of the	To Be C	17. Father's Name (F Roy Bake	irst, Middle, La	ast)			Cook			Name (First, M	iddle, Maid	Food en Surnam	_	tce	
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Balt	Departr Importr any inje		21. Signature of Funeral Service Licensee  22. Name and Address of Facility d. P.A. Funeral Home Reeney & Basford P.A. Funeral Home 106 E. Church Street, Frederick, M.									ne MD :	21701			
- P1	nysician/		23a. Part 1. Enter the shock, or hear Immediate Cause (F disease or condition	t failure. List on Final	complications that ly one cause on e		e death. Do i	not enter the	mode of dyir	ng, such as car	diac or respirat	ory arrest,			Approxima Interval Be Onset and	etween
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Box 68760	been signed by the attending physici should be detached for use as the bu	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent   in the past 12 n 1 ☐ Yes 2 [] 9 ☐ Unknown	nonths?		Birth 2. gnantattin	pregnancy Fetal deat		opic pregnan er (specify)	су				ate of del	ivery Day	Year
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #20c Per ANA BD C930 8/2//2012 III.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 13 20<sup>4</sup>2 1:30 Рм August Harriett Ann Ahalt Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Frederick 7111 Autumn Leaf Ln. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Nov 17, Year 1938 1 M 2 M F **Director** Yrs. Maryland 214-36-0807 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Frederick 1 ☐ Yes 2 🖺 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 21702 7111 Autumn Leaf Ln. USA items ; within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ò ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 x Yes 2 ☐ No Specify: Specify: hispanic "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home 0 housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Celeste Weber Albert Stocksdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 7111 Autumn Leaf Ln; Frederick, MD 21702 Joshua D. Ahalt - husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other place) con University ool of Medicine 1 Burial 2 Cremation 3 Removal from State Boston Boston 4 □ Donation 5 ☑ Other (Specify) in state 8/23/2012 Bonston, Massachusetts 21. Signatur of Euneral ryice Licer ROD 10 S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Occardia disease or condition Medical resulting in death) Due to wr as a consequence of): Examiner MARIAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has page 2 autopsy performed death? 2 🗌 No 1 🗌 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tes 2 🗌 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5  $\square$  Pending Accident 1 🗌 Yes 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: of the found of the interval of the inte Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) જ 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	For State Registrar	State of Mary	yland / Depart Certin	ment of Health ficate of Death	n and Mental Hy	/giene Reg. No. 20	12 27239
Physician/ Medical		e P APP	1e		2. Date of D Month Augi	Dav	3. Time of Death 3:09 am
Examiner	Atlantic	ution, give street and number) General Hospita	e	b. City, Town, or Locatio Berl	in		lorcester
Funeral Director	5. Social Security Number  578-22-2088  Usual Residence of Deced	1 □ M 2 💢 F		f Under 1 Year If Und onths Days Hours			9. Birthplace (State or Foreign Country)  New York
aryland a-f show fied at	101 0	punty 10	C. City, Town or Locati				10d. Inside City Limits 1 ☐ Yes 2 🌠 No
death with the Maryland items 23a or 28a-f sho ner must be notified at Funeral Director	Maryland 10e. Street and Number	Worcester		10f. Zip Code	an City	10g. Citizen of V	Vhat Country?
fter death with the Maryland fter death with the Maryland or items 23a or 28a-f she aminer must be notified at by Funeral Director	1330	12. Was Decedent Ever Armed Forces? 1 \( \text{Yes} \) 2 \( \text{X} \) No	in U.S. 13. Was	218 Decedent of Hispanic ( s, specify Cuban, Mexic	42 Origin? (Specify Yes or No can, Puerto Rican, etc.)	- 14. Race	U.S.A. e - American Indian, k, White, etc.
ind 21215-0036 ind 21215-0036 filed within 72 hours after death with the Maryland tal Hygiene. tal Hygiene. do other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at the Be Completed by Funeral Director	1 Never Married 2 3 Widowed 4 Dive	If Voc Civo		Yes 2 X No Spec	ify:	Specify:	white
nd 21215-003 and 21215-003 al Hygiene. al Hygiene than "natural" to ther than "natural" went, the Medical Example ted	(Specify only Elementary/Secondary (0	highest grade completed)	(Give kind	t's Usual Occupation d of work done during m dOT use retired) Homemaken		16b. Kind of Bu	osiness/Industry  Own Home
and 2  and 2  be filed wi martal Hygick ked other c event, il	17. Father's Name (First, Mid	Idie, Last)  Rudolph Poms			other's Name (First, Middle	n, Maiden Surname Sattles	)
Nore, Maryland 2:  Nore, Maryland 2:  ge 1 and 2 should be filled win  tr of Health and Mental Hygic  tr of the Health and Mental Hygic  or other traumatic event, #	19a. Informant's Name/Rela	tionship (Type, Print)			nber or Rural Route Numb	er, City or Town, S.	tate, Zip Code)
2	Lows Appa 20a. Method of Disposition 1 X Burial 2 Crema	ation 3 Removal from State	20b. Place of Dispositi cemetery, cremate	on (Name of ory or other place)	Date	20c. Location -	City or Town, State
P2012 Baltimo permit. Page Department timportant: Il any injury or	4 Domation 5 Ot  21. Sign (ure of Funeral)		22. N	ame and Address of Fac	08/23/2012  Cility Hines-Ring	aldi Fune	ral Home, Inc. oring,MD 20904
3/21	23a. Part 1. Enter the discasshock, or head fails re.	se, or complications that caused the List only one cause on each line.					Approximate Interval Between Onset and Death
Physician/ Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a co	insequence of):	ect Inf	- <b>- -</b> -		24 hours
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b		e or Ear	Chick		C4 PIGIT
760 Sate be executed physician and such surial-transit edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ensequence of):				
		d	aragnancy.				
Box death death ne atte ed for	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 Live Birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3 🗌 E	ctopic pregnancy ther (specify)		23d. Dat	e of delivery nth Day Year
S the Second of	Part II. Other significant co	nditions contributing to death but n					ibute to the cause of death?  3 Probably 4 Unknown
S S S D	A+	rid Fibrilla	h'on		24a. Wa	s an 24b. V	Vere autopsy findings available prior to completion of cause of
Frude P.  of Vital Record  g Physician: The law requ  ter this certificate has been  neral director, page 2 shou  te: To Be Complete	25. Was case referred to med examiner?					formed? comed? 1	death?
Sion of Vital R Sion of Vital R Attending Physician: Th cleath. sctor: After this certificate by the funeral director, pa	1 Yes 2 No	Hospital:  1 Inpatient  28a. Date of injury (Month, Day, Ye	2 ER/Outpatient 28b. Time of injury	28c. Injury at work?		idence 6 Cothe	
Division of Division of all or Attending Properties after death.  If Director: After the director: After the funeral Certificate:	2 Accident In 3 Suicide 6 C C 4 Homicide de	vestigation fould not be etermined 28e. Place of Injury - building, etc. (S	At home, farm, street, pecify)	M 1 Yes 2 factory, office	28f. Location	(Street and Numbe wn, State)	er or Rural Route Number,
Apple, Eerfrude  Division of Vital Rec  To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  Medical Certificate: To Be Com	29a. Certifier 1 Certifier (Check 2 Med	ifying Physician: To the best of my ical Examiner: On the basis of exam	iination and/or investiga	tion, in my opinion, death	occurred at the time, date	and place, and due	to the cause(s) and manner state
To the within To the comple	29b. Signature and title of ce	riving Nurse Fractitioner To the beartifier	et of my knowledge, de	29c. License numbe	r		(Month, Day, Year)
5V	30. Name and address of pe	rson who completed cause of death	1 (Item 23a) (Type, Prin		·		
State Registrar	31. Date filed (Month Pay X	rson who completed cause of death (1997)	Sign		,	. , , ,	

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 130 PM 2011 911 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HOSBITE SECOUIS NIA KI/TIMO AC B171 4016 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 8. Date of Birth 1 M 2 XF Months Days 215.30.776do Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Baltimore 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21216 Walbrook Avenue Apt. 702 USA items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Specify: [3 ack Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important. If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Health Care 12th grade Home Health Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roger Payne Dora Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Lynn Morgan 9202 Sylvan Dell Road Randall stewn MD 21133 Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Druid Ridge Cemetery! Pikesville, MD 80 28/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Pinera (Services Vau Road Handallstown MD 21123 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or peart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) NEUNINIA Medical Examiner 01171047100 Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine the Hospital or Attending Physician; The law requires that the death certificate be executed and-tran Due to (or as a consequence of) anding physician are as the burial-Physician/Medical THE REPORT OF WEDLEST EXAME P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery atten for u 3 Ectopic pregnance
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month 4 ☐ Pregnant at time of death 9 ☐ Unknown I signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No 잍 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? /21/12 Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Locatio (Street and Number or Rural Route Number determined City or Town, State) B1/71 1018 2000 Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) completed cause of death (Item 23a) (Type, Print) RalTIMOR 2000 BATIMONE ST w,

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Gloria Hall Bridgeford <u>August</u> 11:50A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death NA **Examiner** 4b. City, Town, or Location of Death Joseph Ritchey Hospice Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-05-38 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 212-36-5491 **Director** 74 1 M 2 X F MD Usual Residence of Decede or 28a-f show notified at 10a. State 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. if them 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 313 Gilmor Street 21217 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: American Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel County Elementary/Secondary (0-12) College (1-4 or 5+) GED 2yrs. Custodian School System To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dailey Robinson Gales permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic & John R. Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 714 W. Vine Street Baltimore, Maryland 21201 Jacqueline Hall-Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other p King Mem. Park 1 X Burial 2 Cremation 3 Removal from State 08-30-12 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicans) myelogenous disease or condition Medical resulting in death) Due to (or as a consequen in of): **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the attending physician and Due to (or as a consequence of) resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by myeloma Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 X No Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Vatural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DS1788 23-2012 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tim Polik, MD 6115 Falls 0 Baltimore #300 Tim 31. Date filed (Month).

AUG 2 32. Registrar's Signatur State

Registrar

11:50am

812311

Hall-Bridge Frol

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <sup>Day</sup> 2012 Betty Sass Bareham Aug. 23, 1318 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Columbia nder 1 Year | If Under 24 Hrs. Howard Social Security Number 7. Age (In vrs. last birthday) **Funeral** If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director Country) 217-24-3910 83 1 🗆 M 2 🛣 F Usual Residence of Decede 16, 1928 Maryland er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Jessup 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9950 Guilford Road 20794 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. δ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: 3 XWidowed 4 Divorced Specify: Caucasian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygie 27 is marked other r traumatic event, the <u>ectronic Technician</u> Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Sass Jeneva Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly A. Blodgett/daughter 17258 Hardy Road Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗌 Burial 2 🛛 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Journey Crematory 8/25/12 Woodbine, MD 21. Signature of Francial Service Licensee 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown Dav Year signed by the a d be detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown 24b. Were autopsy findings available prior to completion of cause of page 2 s Physician: The law After this certificate has autopsy performed? 1 ☐ Yes 2X No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospice 1 ☐ Yes 2 🖫 No မ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral dia 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cer 29d. Date signed (Month, Day, Year) D72139 August 24, 2012 dress of person who completed cause of death (Item 23a) (Type, Print) Syed Q. Abbas, MD 6336 Cedar Lane, Columbia, MD 21044 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 06-2011

Brand, Horst 8/25/2012 1057am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Manyland / Department of Health and Mental Hygions

			For State	State of M	-	epartment of h		Mental Hy	giene						
			Registrar		Death	Reg. No. 20 2 272									
ı	Physicia Medic		Decedent's Name (First, Middle, L	Horst	Brand			2. Date of Dea Month Augus	ath t 25, 20	3. Time of Death 10:57a M					
	Examir		4a. Facility Name (if not institution, g.	,		4b. City, Town, or	Location of Death		4c. County	County of Death					
17		•		n Hospital	ge (In yrs. last birth	day) If Under 1 Year	Bethesda I If Under 24 Hrs.	_			gomery				
	Funeral Director	ı	050-12-6028	1 X M 2 □ F		Months Days	Hours Min.	8. Date of Birt (Month, Day	y, Year)	Birthplace (State or Foreign Country)					
	, mo		Usual Residence of Decedent		92			10/28	/1919		ermany				
	ryland I-f she ied al	Director	10a. State 10b. County	<i>t</i>	10c. City, Town		Prot Cat	inc		10	0d. Inside City Limits 1 ☐ Yes 2 🗶 No				
	ne Ma or 28¢	Dire	Maryland Mon  10e. Street and Number	tgomery		10f. Zip Code	ilver Spr	zng	10a. Citizen of V	Vhat Count					
	with the same same same same same same same sam	Funeral	2901 S. Leisure	world Blue	l., #339		20906		rog. Onizeri oi v	u.s.	*				
	ified within 72 hours after death with the Maryland tal Hygiene. So or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 【X Married	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)							
21215-0036	s afte ral", c Exarr	Completed by	3 ☐ Widowed 4 ☐ Divorced	I My Yes 2 □ If Yes, Give Year or Dates.	1945	1 ☐ Yes 2 🌠 No	Specify:		Specify:		White				
5-0	2 hour "natu dical	plet	15. Decedent's (Specify only highest	Education	16a. I	Decedent's Usual Occup Give kind of work done o		ring	16b. Kind of Bu						
121	thin 77	om	Elementary/Secondary (0-12)	College (1-4 or		ife. DO NOT use retired)		arry	To Jo	4 m D /	7				
d 2	filed wit al Hygie d other event, th	Be C	17. Father's Name (First, Middle, Las	5+		Econor	18, Mother's Nam	o /Eirot Middlo			3overnment				
Maryland		10	,	Leo Brand		İ	10. MOLITER'S INAIL		a Straus	· · · · · · · · · · · · · · · · · · ·					
lary	2 should bethe and Merits and Merits and Merits transfective transfect	100	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Street a	and Number or Run	al Route Number	r, City or Town, Si	ate, Zip C	ode) 20906				
	2 = 2 +		Ruth Brand	Spouse	290	11 S. Leisw	re World	Blud.,#	339,Silv	er Sp	oring,MD				
nore	-==0		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe		cemetery	Disposition (Name of crematory or other place Memorial G/	e)	Date 6 / 2 0 1 2	20c. Location -	•					
Baltimore,	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	37	Judean	22. Name and Addres	ss of Facility Hin	es-Rina	ldi Fune	ral t	Home, Inc.				
ш	o a m no	100	23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
	. CHARLES		shock, or heart fadure. List only Immediate Cause (Final	one cause on each line	Э.		g, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death				
	Physician Medical Examiner	- 10	disease or condition resulting in death)	d.	vry Arter a consequence of	ly Disease				$\rightarrow$	Onder and Boatin				
Specific .		L	Sequentially list conditions,	h.	a consequence of	,									
	ed Isit	Examine	if any, leading to immediate cause. Enter Unidenlying Cause (Disease or injury	Due to (or as	Due to (or as a consequence of):										
	ate be executed bhysician and the burial-transit	Еха	that initiated events resulting in death) Last	c. Due to (or as	Due to (or as a consequence of):										
09	e be e ysicial le buri	edical		<b>d</b>											
876	tificat ng ph	Med	IF FEMALE:												
Box 687	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregnanc			23d. Date of delivery						
Bo	ires that the death certific signed by the attending p d be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	5 Other (specify)			Mor	.tn L	Day Year				
P.O.	that the	by Pr	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying cause giv	en in Part I.	23e. Did to	bacco use contri	23d. Date of delivery  Month Day Year  o use contribute to the cause of death?					
S,	requires been sign should be	ed b	Severe Caloric	-Protein Mo	alnutrit	ion		1 🗆 Y	ably 4 💢 Unknown						
Sor	aw rec as bee 2 sho	Completed	Anemia					24a. Was a	24a. Was an 24b. Were autopsy findin prior to completion						
Be	sician: The law r certificate has b lirector, page 2 s	Con						perfor		eath?					
ta	ician: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Checi								
Ž	Phys	12	1 Yes 2 No 27. Manner of Death	1 X Inpati	ent 2 ER/Outp		4 ☐ Nursing Ho		ence 6 Other						
o u c	nding ath. r: After	icate	1 X Natural 5 Pending 2 Accident Investigati	(Month, Day		ury work	Yes 2 No	28d. Describe no	ow injury occurre	jury occurred					
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certificate:	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Inju						28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Ω	ospital hours uneral I	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, de	eath occurred at the time	, date and place, a	nd due to the ca	use(s) and manne	r as statec	d.				
	the H thin 24 the Fi		only one) 3 L Certifying Nu	riner: On the basis of e	e best of my knowl	nvestigation, In my opinio edge, death occurred at the	ne time, date and pla	ace, and due to th	ne cause(s) and ma	anner as sta	ated.				
	5 Wil		29b. Signature and title of certifier	( Jue 1 1 1		29c. License		2	29d. Date signed						
	\		30. Name and address of person who	0 100	eath (Item 23a) (Tv		71517		Augu	51 25	, 2012				
	67 7		Natalia M. Vasq	uez, M.D.,	8600 Ola		n Road, B	ethesda	, Maryla	ind 20	2814				
	Stat Registra	-	31. Date filed (Month, Day, Year)  AUG 2 7 2012	32. Registra	ar's Signature										
-			AUG MI CUIC	Marie Land	· Commence										

RUdolph L. Bell 12-06226 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNK UNK State of Maryland / Department of Health and Mental Hygiene 2012 27244 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day August 18, 2012 **Medical Examiner** 1307 hrs 4a. Facility Name (if not institution, give treet and number) 4b. City, Town, or Location of Death 4c. County of Death 1607 West Lexington Street Baltimore 5. Social Security Number 6 Sex 7. Age (in vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Director 1 M 2 F Usual Residence of Decedent Inv 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No 28a-f show , or items 23a or 28a-f shorr must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.
nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho ar other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian, Black, is marked other than "natural", or items atic event, the Medical Examiner must be Armed Forces? White, etc. 1 Never Married 2 Married If Yes, Give Year 4 Divorced 1 Yes 2 No specify: ۵ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 abl 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be nar 19a. Informant's Name/Relationship (Type, Print) (\$13 Rural Route Number, City or Town, State, Zip Code) ၉ 19b. Mailing Address (Street and Number ter) 20b. Place of Disposition (Name of ce 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify 1130h n Jure of Funeral Service Licen 22. Name and Address of Facility )Ho in S nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** List only one cause on each line Between Onset and /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED AMENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. á 1 Yes 2 No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of After this certificate has death? performed' 1 🗸 Yes ✓ Yes 2 No 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other; Scene Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day Year Aug 18, 2012 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Subject shot by police 1233 hrs 5 Pending 1 Yes 2 V No within 24 hours after death.

To the Funeral Director: the 2 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 1607 West Lexington Street, Baltimore, MD 4 V Homicide (Specify) Vacant Building 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E August 19, 2012 hell 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) AUG 2 7 201 State 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

Registrar

**ORIGINAL** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 8:34 A M Carter Agnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Joseph Ritchey Hospice Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month Day, Year 05-27-30 214-64-0804 82 1 □ M 2 🏝 F Director MD Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f sho other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland Director Baltimore 1 Yes 2 No NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21216 1649 N. Fulton Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. African Armed Forces?

1 Yes 2 XNo permit, Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent if I fram 27 is marked other than "nature" any Injury or other terms. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: Specify: American If Yes, Give 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Becker Potato Elementary/Secondary (0-12) 8th Grade College (1-4 or 5+) Chip Factory Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Chappell O'Neil Annie Percel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1649 N. Fulton Avenue Baltimore, Maryland 21216 Diana Quarles-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
King Mem. Pk. 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 08-29-12 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, Maryland 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 3 WEEK TREBROVASCU disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be execution within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the burlal-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 1 🗌 Yes æ Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in musciples. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certif ss of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUGUST Andrew John Calabrese, Sr. 8:26 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours 218-44-2615 Country) Director 67 1 👿 M 2 🗆 F MD 12-26-1944 Usual Residence of Decedent show 10a. State 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MD Anne Arundel Glen Burnie 1 🗌 Yes 2 🗶 No 10e. Street and Number ms 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 48 Birch Ave. 21061 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. b 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing 12 Checker - Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Calabrese Irene Waddell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Calabrese / Wife 48 Birch Ave., Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place)
Holy Cross Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 108/28/2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ventricula Onset and Death Physician/ fibrilla tuon disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant a 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform Yes 2 No 1 🗌 Yes 2**/** No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 Inpatient 2 KER/Outpatient 3 IDOA this of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniury Division work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: A

completely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition or T. Inc. Deat of my how does not consider the time. Cate and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 063726

Registrar

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State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

majerod

Mary

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kunmi
(40h Soull\_Crum \Hohman Cum

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DAVID COHEN 06: (OA M agust Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Rospital of Battimore Battimore N/A 5. Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral Days Min. (Month, Day, Year) Director 050-30-1304 1 X M 2 □ F 75 03/23/1937 NY permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mentel Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutiled at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No RANDALLSTOWN BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21133 3930 ALGIERS ROAD IISA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify. 3 Widowed 4 Divorced Specify: Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 **PROOF** READER PRINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည COHEN RIKETA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGENE COHEN / WIFE 3930 ALGIERS ROAD, RANDALLSTOWN, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DHEB SHALOM MEM. PARK 08/24/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Lice see 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic Physiciani colon cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami ettending physicien end I for use es the buriel-transit Hospital or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 No ed by the e 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sl ral director, page 2 should mellitus type 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Tes Other: 4 Nursing Home 5 Residence 6 Nother (Specify) hospice 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours effer deeth.

To the Funeral Director: Afti completely filled in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 7033 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print) Bel redere Ave, Baltimore, MD 21215 Tr. -ilun Z

State Registrar 31. Date filed (Month, Day, Year)

state of Maryland / Department of Health and Mental Hygiene 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Charles C. Davis Sr. 2012 PM 2:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1022 E. Biddle Street Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Min. (Month, Day, Year) Days Director 219-62-2073 1 X M 2 D F 57 Yrs. 7/6/1955 MD Usual Residence of Decedent or 28e-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours efter death with the Marylend Deportment of Health and Mentel Hygiene. Importent: If item 27.5 is merked other then "neture!", or items 23e or 28e-f sho eny Injury or rother treumstic event, it in Wadical Examiner must be notified. 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 1022 E. Biddle Street 21202 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 2:450m Maryland 21215-0036 1 Yes 2 No Specify: Specify:Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) UNKNOWN 10th Truck Drive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Davis Mary Felton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lacey-Mother Cliftwood Ave. Baltimore, MD 21213 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Site Crematory 8/25/2012 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East North Ave. Baltimore, 21202 MD23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tancreatic carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ettending physicien end for use es the buriel-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day signed by the et to deteched for 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Physicien: The lew requires that the ete hes been signed by pege 2 should be detect Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physicien: the within 24 hours after death.

To the Funerel Director: After this certificate I completely filled in by the funerel director, peg 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other:
4 Nursing Home 5 Residence 6 N Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and fitle of certifier 29d. Date signed (Month. Day, Year) Menino 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Camille Menino 10710 Charter Drive Ste: 240 Columbia, MD, 21044 31. Date filed (Month, Day, Year) State AUG 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month M A KCZ 7017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Wes 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Country) Director 53 Yrs item 27 is marked other than "naturel", or items 23a or 28e-f sho other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21214 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 XNo If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Mygiene. College (1-4 or 5+) Dast Be 17. Father's Name (First, Middle, Last) Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumatic even once. 18. Mother's Name (First, Middle, Maiden Surname) မ 0 ohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses MARCH 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed Yes 2 death? 25. Was case referred to medical Be examiner? 2 No 2 1 Tes Other: 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division 1 Yes 2 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certif 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOCKIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 7 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend 20b, per fh. g931 9-13-12 sm
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DENIS JAMES DOWNEY **AUG** 4:50 p M 14 2012 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WALTER REED NATIONAL MILITARY MEDICAL BETHESDA 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours **Director** 224-52-7612 1 🛛 M 2 □ F 88 01/29/1924 Kansas Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2X No Virginia Fairfax McLean 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? marked other than "natural", or items 23a o matic event, the Medical Examiner must be Funeral 7004 Girard Street 22101 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 1976 Specify: Completed Year or Dates Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Naval Officer Navy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Denis-John Downey Camille V. Siebt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sl ment of Health a tant: If item 27 i Denis-James J. Downey, Jr./Son 4104 Middle Ridge Drive, Fairfax, Virginia 22033 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Arlington Natl. Cem. 12-28-2012 Arlington, Virginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility Everly Funeral Home 10565 Main Street, Fairfax, Virginia 22033 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. RESFIRATORY FAILURE Medical Due to (or as a consequence of) Examiner ASPIRATION PNEUMONITIS Sequentially list conditions. Examine cause. Enter Underlying Cause injury Due to (or as a consequence of) requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) physician al s the burial-1 Physician/Medical Box 68760 inding pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) for in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day Pregnant at time of death Month Year ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗓 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 은 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director, A 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Proatitionar: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

CHRISTOPHER D. NELSON

2 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

32. Registrar's signature

29c. License number

02003622A

BETHESDA, MD 20889-5600

29d. Date signed (Month, Day, Year) 08/15/2012

WALTER REED NATIONAL MILITARY MEDICAL CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10a-c,e,f,perFH,G932,10/17/2012,WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 2725 |

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	Funeral Director			Social Security Number 6. 213–28–2356	. Sex 7. Age 1 ☐ M 2 🗓 F	(In yrs. las	st birthday)	If Under 1 Year Months Days	Hours	r 24 Hrs. Min.	8. Date of Birth (Month, Day		9. Birthpi Counti	lace (State or Foreign ry)		
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	faryland 8a-f shov tified at	Director	10a. State	10b. County	N/A 10c. City, Town or Location Baltimore					-				10d. Inside City Limits 1x√ Yes 2 □ No											
	with the N 23a or 2 1st be no	Funeral Di	10e. Street and Num 1534 (	clarkson	Street			10f. Zip Code 21230						log. Citizen of What Country?  USA											
9036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  2. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1	S. 13	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)      □ Yes 2 ▼ No Specify:						14. Race - American Indian, Black, White, etc. Specify: White														
215-0	<b>an "natu</b> Medical	Completed		15. Decedent's E	ade completed)		(Give	e kind of w	sual Occupa rork done o rse retired)	ation during most	of workir	ng	16b. Kind of Business/Industry												
1212	iled within I Hygiene. other thai	To Be Cor	Elementary/Secon 9	, ,	College (1-4	1 or 5+)			Oper:					anufa	ctur	ing									
Maryland 21215-0036	ould be filed nd Mental Hy marked oth imatic event		17. Father's Name (F. Willia	am T. Epl					r's Name E <b>rma</b>	(First, Middle, Lodw:		Surname)													
e, Mar	and 2 should be tealth and Ments wm 27 is marked her traumatic e			s R. Epli			1301	And	re St			Route Numbe	MD	21230											
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		4 Donation	☑ Cremation 3 ☐ 5 ☐ Other <i>(Specii</i>	y)	State Cre	Place of Disp cemetery, cre ematic	ematory or	other place	of MD		ate 27/2012		ocation - C		<sub>wn, State</sub> ryland									
Bal	permit Depar Impor any in		21. Sprature of 1	eral Service Licens	Victor	r P. Do	oda 1	Char 501	and Addres	ss of Facility Stev	vens	Funera	al H	ome,	Inc.										
Shock, or heart failure. List only one cause on each line.  Interva Onset  disease or condition  Ta' WPC										Approximate Interval Between Onset and Death															
	Medical Examiner		resulting in death)  Sequentially list con	ditions		r as a consequ EXCERI	,																		
	executed an and rial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  PNEUMONIA  Due to (or as a consequence of):  d.																						
		edical																							
. Box 68760	to the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Tunaral Director, After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burians.	by Physician/M	d by Physician/Me	by Physician/M	d by Physician/M	d by Physician/M	Completed by Physician/Medica	d by Physician/M	nysician/M	ysician/M	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?		irth 2 🗌 Feta ant at time of o	al death 3	☐ Ectopic ☐ Other (	c pregnanc specify)	у				23d. Date Mont		ry Day Year	
s, P.O.	requires that the dec been signed by the a should be detached								Part II. Other signific Hepatiti		ontributing to dea	ath but not res	ulting in the	underlying	g cause give	en in Part I.		1				e cause of death?			
cord	law requiras been a 2 shoul	nplete										24a. Was	an	24b. Were autopsy findings available prior to completion of cause of			able								
- Re	Physician: The law this certificate has al director, page 2		25. Was case referred	5. Was case referred to medical						ace of Death	/Chank	1 \( Yes	2 N		ath? Yes	≥ <b>∑</b> No									
Vita Vita	nysicia iis cert i direct	To Be	examiner?	ŀ	Hospital:	patient 2 🗆	ER/Outpatie	ent 3 🗌 I	- Cul	r:		Home 5 ☐ Residence 6 ☐ Other (Specify)													
Division of Vital Records,	al or Attending Phy s after death. I Director: After this id in by the funeral (	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined Phomicide Suicide 1 Pending Investigation 28e. Place of Injury - At home, farm, streed building, etc. (Specify)						28c. Injury work?	at	2	28d. Describe how injury occurred													
Divisi	e Hospital or Att 124 hours after d e Funeral Direct letely filled in by								reet, factory, office 28f. Location (\$\text{City or Tov}\$					(Street and Number or Rural Route Number, wn, State)											
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	(Check 2 L	Certifying Phys Medical Exami Certifying Nurs	ner: On the basis	of examination	n and/or inve	stigation, i	n my opinioi	n, death occ	urred at t	he time, date a	and place	e, and due to	the caus	se(s) and manner s	stated.								
29b. Signature and title of certifier  Zhigang Liu /MD  29c. License number  RES 00									29d. Da 7 W.	te signed (	Month, D	ay, Year)													
			30. Name and addres	Liu 3	ompleted cause		23a) (Type,		treet	; Bal	tim	ne 1	11)	210	115										
	Stat Registra	-	31. Date filed (Month, AUG 27		32. Rec	nistrar's Signat	ture																		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Herbert Emerson Forrest August 22. 2012 8:45a™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Emeritus Senior Living Montgomery Potomac 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) Director 078-18-8285 1 XM 2 □ F 88 09/20/1923 New York show ital Hygiene. 3d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Bethesda Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8706 Bellwood Road 20817 u.s.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1943—
If Yes, Give
Year or Dates. 1946 þ Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Elementary/Secondary (0-12) College (1-4 or 5+) Lawyer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jacob Forrest Rose Fried traumatic 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is nany injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn Forrest - Son 926 Willowleaf Way, Potomac, Maryland 20854 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 🔲 Removal from State 08/24/2012 Judean Mem. Gardens Donation 5 Other (Specify) Olney. Maryland nature of Funeral 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. ice Lidensee M0070 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the d shock, or heart fa ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between lure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Cerebral Thrombosis with Cerebral Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Coronary Arterosclerosis if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of that the death certificate be executed Hypertension and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Diabetes Mellitus Type 2 Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Pregnant at time of death Month Year 1 Yes 2 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy page performed?

Yes 2 X No death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Senior 1 Tyes 2 **X** No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) iving 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. Accident Investigation the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely To the I within 2. 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month. Day, Year, R096053 August 22, 2012 12x1. 30. Name and aderess of person who completed cause of death (Item 23a) (Type, Print) Babette Pennay, 15245 Shady Grove Road, #130, Rockville, Maryland 20850 CRNP,

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	aryianc	•	tificate of E		ı ivlerilar n	ygiei Reg. I	001	2 27254
	Physicia	n/	1. Decedent's Name (First, Middle,	Last)					2. Date of D		Day Year	3. Time of Death
	Medic			raham, Jr.					Augus	st :	25 2017	
	Examin	er	4a. Facility Name (if not institution,	,			4b. City, Town, or		ath	4c. County of Death		
			Union Memori 5. Social Security Number		(In yrs. las	at bright days	Balti If Under 1 Year	more If Under 24 H	rs. 8. Date of E	Sant In	NA 0.0	
	Funeral Director		212-44-6101 Usual Residence of Decedent	1 X M 2 D F	66	Yrs.	Months Days	Hours M		Day, Year	r) 9. B	irthplace (State or Foreign ountry) SC
	and show at	'n	10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Limits
	//aryle/8a-f	rect	MD	NA	Bal	ltimor	e					1 🏋 Yes 2 □ No
	the last	ä	10e. Street and Number				10f. Zip Code			10g.	Citizen of What (	Country?
	h with	Funeral Director	5811 Highgate	Drive				215			J	JSA
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 🏝 Marri 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🛣 I If Yes, Give Year or Dates.		If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - Am Black, Wh Specify: An	<sup>lerican Indian,</sup> i <sup>ite, etc.</sup> African nerican
5-0	2 hou "natu edical	plet	15. Deceden (Specify only highes	's Education t grade completed)			ent's Usual Occupa		vorking	16b.	. Kind of Busines	s/Industry
121	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. D	O NOT use retired)			l R	oofing (	ompany
d 2	ed wi Hygie other ent, tl	Be (	10th Grade  17. Father's Name (First, Middle, La	NA NA		7	Roofer 	18. Mother's I	lame (First, Middl			omparry
an	be filed ental Hy rked oth ic event	1		am, Sr.				Mildre		Lee	,	tley
ary	should be file and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationsh	p (Type, Print)	, III	19b. Mailin	g Address (Street a	and Number or	Rural Route Numl	ber, City	or Town, State, 2	Zip Code)
Σ	and 2 s Health tem 27 is		Johnola Graham-	Wife		5811	Highgate	Drive	Baltimor	e, l	Maryland	1 21215
Baltimore, Maryland 21215-0036	permit. Page 1 a Department of H Important: If ite any injury or otf		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		cer	metery, cren	sition (Name of natory or other plac 1. Park	e) 08	Date -27-12	1	Location - City of andallst	
Balt	permit. Departi Import any inji		21. Signature of Funeral Service Li	censee	TA.		Name and Addres		Wylie Fu reet Bal			P.A. yland 21217
			23a. Part 1. Enter the disease, or on shock, or heart failure. List or	complications that caused ly one cause on each line.	the death.							Approximate Interval Between
	Ph <sub>sician</sub> Medical		Immediate Cause (Final disease or condition resulting in death)	a	cardio		farction					Onset and Death  1 day
	Examiner			Due to (or as a	conseque	,						3 days
À		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a								- , ,=
B	cuted ind transi	xam	Cause (Disease or injury that initiated events	c								
J	oe exe ician a burial-	edical Examiner	resulting in death) Last	Due to (or as a	conseque	nce on:						-
760	cate t			d				· ·				
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic pregnanc Other (specify)	у			23d. Date of d Month	elivery Day Year
ls, P.0	uires that than the signed by	by	Part II. Other significant condition	ns contributing to death bu	ıt not resul	ting in the u	nderlying cause giv	en in Part I.				to the cause of death? Probably 4 🗗 Unknown
Secor	he law requite has beeloage 2 shou	Completed							24a. Wa aut per 1 🗌 Yes	opsy formed?	prior to	utopsy findings available completion of cause of
a	sian: T	Be C	25. Was case referred to medical examiner?				26. Pla	ace of Death (C			NO .	
₹	hysic this ce al dire	욘	1 Yes 2 No	Hospital:		<del></del>		4 L Nursin	Home 5 ☐ Re	sidence	6 Other (Spe	ecify)
10	ding P	Certificate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending			8b. Time of injury	28c. Injury work	?	28d. Describe	how inj	ury occurred	
Sio	death death ctor: y the	tific	2 Accident Investig 3 Suicide 6 Could n	ot be	v - At hom	ne. farm. stre		Yes 2 No	28f Location	(Street	and Number or B	ural Route Number,
Ξ Ž	al or A s after Il Dire	Cel	4  Homicide determin	building, etc.		,,	, /,,		City or To			oral ricotto riconscor,
_	e Hospit 24 hour e Funera	Medical	(Check 2 Medical Ex	Physician: To the best of r aminer: On the basis of ex Nurse Practitioner: To the	amination a	and/or invest	igation, in my opinio	n, death occurr	ed at the time, date	and pla	ce, and due to the	cause(s) and manner stated.
	To th Withii To th COMF		29b. Signature and title of certifier	~~~			29c. License	number		29d. [	Date signed (Mor	th, Day, Year)
					> M	1. D.	DO	00677	41	1	August, =	25, 2012
			30. Name and address of person w Walid Barbo	ho completed cause of de	ath (Item 2	3a) (Type, P	Blud, 2n	d FL,	Baltim	ore,	MD 2	201
	Stat Registra		31. Date filed (Month, Day, Year)  AUG 2 7 2012	32. Registra	's <del>Si</del> gnatur	re was						

12-06373
Joseph Hoppe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

seph Hoppe		State of Maryland / Department of Health and Mental Hygiene 2012 2725  Certificate of Death  Reg. No.
Physicia		1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month Day Year
edical Examir	ıer	JOSENA HODDE August 23, 2012 2152 nis
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  914 Orems Road  4c. County of Death  Middle River  Baltimore County
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Director	Į	2/9-28-7673 1 M 2 F 80 Yrs. Months Days Hours Min. 5-21-1932 Country) MD
y.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
dow any		1 Yes 2 No
Maryland 28a-f show d at once,	泉	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once,	ă	914 Orems Road 21221 USA
th with	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 4 Married 5 Married 5 Married 5 Married 5 Married 6 Married 7
er dea		3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No No specify: Specify: Specify: White
15-0036 filed within 72 hours after death with the Maryland I Hygiene ed other than "natural", or items 23a or 28a-f ahe t, the Medical Examiner must be notified at once	q p	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
hin 72 ho e. than "us edical Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+)
within giene.	Completed	77. Father's Name (First, Middle, Last)  Sharrows Point 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 72 hou Mental Hygiene. marked other than "nat c event, the Medical Exa	Bec	George Hobbe Margaret DietLemeir
ID 21215-00; should be filed within and Mental Hygiene in marked other tin matter event, the Meet	은	19a. Informant  me/Relations ip Type, Print ) 19b. Mailing Address (Street and N mer or Rural Route Number, City or Town, State, Zip Code)
alth 2		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If its		1 Burial 2 Cremation 3 Removal from State crematory or other place)
트 집 일 등 등	-	4 Donation 5 Other Specify: Dayview Cientatory 8/27/12 Baltinore, NO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bray Icy - ASL to N Fune val
Balti permit. Departri Imports		Home, PA 2134 W1/10W SDrive RN. 21222
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and
Medical Examiner	ı	Immediate Cause (Final disease or condition resulting in death)  Death  Death  Due to (or as a consequence of):
		Sequentially list conditions,  b.
No.	ne	if any, leading to immediate  raus. Finter Underlying County
=	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):
recul	ᇛ	d.
	edical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery
Box 6876( death certificate the attending physelor use as the b	Physician/M	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
box (eath ce attence for use	/sici	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown
O, B at the d by the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
ires that to signed by the detact	d by	1 Yes 2 No 3 Probably 4 Unknown
ords w requii	olete	24a. Was an autopsy findings available prior to completion of cause of
Reco	Completed	performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
of Vital Records, ig Physician: The law require ther this certificate has been si meral director, page 2 should be	å	25. Was case referred to medical examiner?   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: Scene
of Vi	<u>د</u>	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
on C ending ath or Af	Certification:	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No Subject shot self
Division tal or Attendin is ter death.	ifica	28e, Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Spital nours neral	Se	Suicide Suicide Gould not be determined (Specify) Home or Town, State)  914 Orems Road, Middle River, MD  29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated.
Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours ter death.  To the Funeral Infector After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To Your Cont	Mec	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)
		Theodon M King JR., m. D. O.C.M.E. OCME August 24, 2012
1		30. Name and address of person who completed cause of de th (Item 231)  The odors NA (King In NAD) Assistant Madrian Examiner 200 M/ Politimore Street Baltimore MD 21223
		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  31. Date filed (Month, Day, Year)  22. Registrar's Signature
Pogist	ate	ALIC OF 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 20°1°2 10:50 Selma Grace Hammerschlag Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bedford Court Assisted Living Montgomery Silver Spring 6. Sex If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Months Hours 2-23-191 085-03-9648 101 Director New York Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 3700 International Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: Completed 3 XWidowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esther Crohn Benjamin Shapiro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Hammerschlag - Son 6901 Hillmead Road, Bethesda, Maryland 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Oheb Shalom Cemetery 8-26-2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature Deneral Service Licens 22. Name and Address of Facility Edward Sagel Funeral Direction Deibler 1091 Rockville Pike, Rockville, Maryland 20852 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1 shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 2 Days Physician/ Multisystem Organ Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) attending physician Physician/Medical ate has been signed by the attending page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \) \( \mathbb{X} \) No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes Mellitus 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Polymalgia Rheumatica autopsy performed? Yes 2 X N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: i within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical æ completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 🗓 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

(Check

Philip Henjum, 31. Date filed (Month, Day, Yea AIIG 2 7 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Registrar DHMH 17 Rev 7/2009

State

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D0035045

18109 Prince Philip Dr., #200, Olney, Maryland 20832

29d. Date signed (Month, Day, Year)

8-24-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ 759 AM 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Tolvn, or Location of Death 4c. County of Death Examiner 100 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Hours Min. Country) I 0 Director 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at **Funeral Director** 1 Nes 2 No more 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number 23a items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Bace - American Indian. 11. Marital Status Black, White, etc. 5 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify: 3 ₩idowed 4 ☐ Divorced "natural" Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event". (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Ò 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Jura Route Number, City or Town, State, Zip Code) Ave Walthe Mз to 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Addr Facilit Russ 21. Sign f Funeral Service Lice Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Physician/ ACLUANCEC disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to for as a consequence of Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months Day Month Year 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed has this certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 14 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2  $\square$  No 1 \sum Yes Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and life of certifler 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) than woods Rd Baltimone 3 O 31. Date filed (Month, Day, Year, Registrar's Signature State AUG Registrar

M DHMH 17 Rev 7/2009

12-06218 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. John Albert Isaac State of Maryland / Department of Health and Mental Hygiene 2012 27258 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Medical Examiner** 1230 hrs August 18, 2012 John Albert Isaac 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4923 Goodnow Road Raltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign West Country) Indies Hours Director 580-10-1167 1 M 2 F 72 4/28/1940 Usual Residence of Decedent 10d. Inside City Limits 10a. State Oc. City. Town or Location 1 X Yes 2 No 23a or 28a-f show MD permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28af sho injury or other traumatic event, the Medical Examiner must be notified at one. N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4923 Goodnow Road Apt. 21206 Indies Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes Specify: Black 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th N/A N/A Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Campbell Margaret Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Janice Isaac-Daughter Devonshire Dr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) X Burial 2 Cremation 3 Removal from State 8/24/2012 Randallstown, 4 Donation 5 Other Specify. Kina Memorial Park 22. Name and Address of Facility 21. Signature of Euneral Service Licenses March F/H- Est. 1101 E. North Ave. Baltimore, 21202 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Intracerebral Hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial -P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed of Vital Records, has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? page ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Other Nursing Home 5 Residence 6 🗹 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification 1 V Natural Division Pending 1 Yes 2 No death Director: filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined 24 hours Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the within 2 To the 1 2 Wedlcaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Laron Locke MD.

2012

OCME

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

August 23, 2012

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Kenworthy **2**012 12:38P. August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funera! Hours (Month, Day, Year) 044-32-2543 1 × M 2 □ F Director 71 October10,1940 Indiana Usual Residence of Decedent 28a-f show 10a, State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🏋 No Maryland Anne Arundel Lothian 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a on event, the Medical Examiner must be Funeral 20711 201 Biggs Purchase Lane U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Systems computer Analysist Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ပ Elizabeth Carter Edwin W. Kenworthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tom Kenworthy 80401 25783 Bristle Cone Court, Golden, Colorado 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) CremationCenterofMaryland Hanover, Maryland 21. Signature of Funeral Service Licensee

\*\*Druckael | Puch 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. mar 6009 Harford Road, Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 10 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami requires that the death certificate be executed ician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ⊒ Live Birth 2 ∟ ⊢eरਬ। ਪਦਕ ⊒ Pregnant at time of death for in the past 12 months?

1 Yes 2 No
9 Unknown Month Year ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ this 1 

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after death.

The Funeral Director: After this impletely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural work Accident
Suicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ithin 2 the F only one) the 29b. Signature and title of certifier 20c License number 29d. Date signed (Month: Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 SUITE 607, ANNAPOLIS GAN MEDICAL PKWY Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Dea MUUS Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8 Knoll Ridge Court Apt #1722 Baltimore If Under 1 Year If Under 24 Hrs.

Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country 214-30-5319 Director 1 □ M 2 🖵 F 05/02/1934 South Carolina 78 "naturei", or items 23e or 28a-f show 10c. City, Town or Location 10d, Inside City Limits filed within 72 hours after death with the Maryland all Hygiene. d other than "naturel", or items 23e or 28a-f showert, the Merikal Examiner must be notified at event, the Merikal Examiner must be notified at 10b. County 10a, State Director Baltimore 1 √ Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8 Knoll Ridge Court Apt #1722 Funeral 21210 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married <u>۾</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Supervisor MD State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental I 27 is marked o r traumatic eve Ella Frank Mander Allen 1 and 2 should to the strand Me I tem 27 is mark other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Knoll Ridge Court Baltimore, MD 21210 James Kemp / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Importent: If it
eny injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carrison Forest VA Cemetery 08.30.2012 Owings Mills, MD 21. Sana ure of Funeral Sovice 22. Name and Address of Facility
John L. Williams Funeral Directors, P.A. 4517 Park Heights Avenue Baltimore, 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician Panckatic Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and I for use as the buriel-transit Exami Cause (Disease or injury or Attending Physician: The lew requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months
1 Yes 2 No Day Year Pregnant at time of death signed by the at id be detached fo g 🗌 Unknown P.0. Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed this certificate has been si rai director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funerel Director: Aft completely filled in by the fur 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D005 7465 29b. Signature and title of certifier MSRajapaneMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 71209 2835 Smin N 5203 NSRajapakseMD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

AUG 27

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 AM therin Medical County of Death Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. anda If Under 24 Hrs. 8. Date of Birth
Dec 28, 1941 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 1 M 2 😾 Months Hours Min. Country) unk Dec **Director** 219-60-6495 70 Usual Residence of Decedent show 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified Dunda1k 1 ☐ Yes 2X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be USA Funeral 21222 113 Center St; Apt 1 items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status "natural", or iten edical Examiner r Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 within 72 hours after white If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced and Mental Hygiene.

is marked other than "natur
aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 611 Central Ave #301; Towson, MD 21204 Donna Brill - legal guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature of Funera Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): executed Cause (Disease or iinjury -tran that initiated events resulting in death) Last Due to (or as a consequence of): burialending physician ruse as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atter t 12 months? in the past 12 ģ Month Day Year Pregnant at time of death 5 Other (specify) the the \_ Yes 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page 2 certificate Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this After this funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who completed cause of

Yea/

27

2. Registrar's Sign

Euclides	Mi 10	Manley
12-06143		P
UNK UNK		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 27262

		1- For State Registrar	Ċ	ertificate of L	Death		R	eg. No.	
Physici	an/	Decedent's Name (First, Middle,Last)					Date of Dea     Month		3. Time of Death
Medical Exami	ner	Euclides M 4a. Facility Name (if not institution, give	ilo Manle		City, Town, or I	Location of D	Month August 16	6, 2012 4c. County of Dea	0041 hrs
		607 Linnard Street	street and number)		Baltimore	Location of Di	saur	4c. County of Dea	NA
Funeral	h	5. Social Security Number 1 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bi		Birthplace (State or
Director		unk.	м 2[]F 35	Yrs.	Months Days	Hours	Min. 10-12	2-76 For	eign Country) MD
	l	Usual Residence of Decedent							
w any		10a. State 10b. County		ity, Town or Location					10d. Inside City Limits  1 XX Yes 2 No
/land -f show once.	호	MD NA	В	altimore				0.00	
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 607 Linnard Stre	o. <del>t</del>	[]	Of. Zip Code 212	29		0g. Citizen of What Co USA	ountry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status	12. Was Decedent Ever in	U.S. 13 Was F			( Specify Yes or No		erican Indian, Black,
eath v item	unera	1 X Never Married 2 Married	Armed Forces?	If Yes,			erto Rican, etc.)	White, etc.	African
after d	by Fi	3 Widowed 4 Divorced			es 2 No	specify:		Specify: Ame	erican
nours a		15. Decedent's Education (Specify onl	y highest grade completed)		Usual Occupati of working life.			16b. Kind of Busines	s/Industry
036 thin 72 hours a ne. than "natura fedical Exami	Completed	Elementary/Secondary (0-12)  12th Grade	College (1-4 or 5+) NA	1	Laborer		,	Berman Mo	ving Storage
J with giene	E	17. Father's Name (First, Middle, Last)	* 11 Y			8.Mother's Na	ame (First, Middle,		
215-00 be filed wit rked other cut, the Mi	Be	Charles M.	Manley			Agust		Garcia	
21 tould b d Mer s mar	흔	Charles M.  19a, Informant's Name/Relationship (Ty				and Number	or Rural Route Nur	nber, City or Town, Sta	te, Zip Code) 21244
MD 21215-0036 rd 2 should be filed within 7 and Mental Hygiene. m 27 is marked other than aumatic event, the Medica		Ronda Taylor-Moth			_			Randallst	
TOFE, ages l ar nt of Hez		20a. Method of Disposition  1 X Burial 2 Cremation 3	Removal from State	b. Place of Disposition crematory or other King Mem.	n (Name of cerr place)		Date	20c. Location - City	stown, MD.
LimC Page ment tant: or ot	ļ	4 Donation 5 Other Specify:					3-21-2012		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licens	e e		ne and Address			neral Home	
Physician	7	23a. Part I. Enter the disease, or compli	cations that saused the dea						aryland 21217 Approximate Interval
/Medical		failure. List only one cause on eac	h line. Gunshot Wound of H						Between Onset and Death
Examiner			ue to (or as a consequence						
7	Ļ.	Sequentially list conditions, b		0-					
	틸	cause. Enter Underlying Cause	ue to (or as a consequence	e or):					
it. g V	Examiner	(Disease or injury max mittaced events resulting in death) Last	ue to (or as a consequence	e of):					
50, te be executed hysician and burial - transit		UNPENDED d	AMENDED ,,						+
SO, te be e tysicia	Medical	IF FEMALE:	#20b, pe	erFH, G932.	10/15/2	012.WS		23d. Date of delive	any and
Box 68760, death certificate be the attending physicidion of the buring as the buring of the buring		23b. Was decedent pregnant in the past 12 months?	1 Live birth		death 3	Ectopic pre	gnancy	Month Month	Day Year
Sox 687 death certifit e attending for use as t	Sici	1 Yes 2 No 9 Unknown	4 Pregnant at time of	death 5 Other	(Specify)				
the de ched f	Physician	Part II. Other significant conditions	9 Unknown	ot resulting in the und	erlving cause gi	iven in Part I.	23e. Did to	obacco use contribute	to the cause of death?
P.O. res that the signed by be detach		J	<b>.</b>	<b>y</b>	,		1 Yes	s 2 No 3 Pr	obably 4 Unknown
of Vital Records, of Vital Records, og Physician: The law require then this certificate has been si neral director, page 2 should t	Completed by						24a. Was		autopsy findings available
SCO!	ם						autor perfo 1 ✓ Yes	rmed? death?	
#200 Vital Rec ysician: The I his certificate   director, page		25. Was case referred to medical		<del></del>	26.Place	of Death (Che		2 10 1	Tes Z NO
this ce direct	To Be	examiner? 1 ✓ Yes 2 No	spital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nu	rsing Home 5	Residence 6 🗸 Oth	er; Scene
Of ing Pl		27. Manner of Death	28a. Date of Injury FOUND:	28b. Time of Inju		y at Work?	28d. Describe Subject sho	how injury occurred	
sion ttend death. ctor:	jati	Natural 5 Pending Accident Investigation	Aug 16, 2012	0040 hrs		es 2 🗸 No			
Division of Patending Phous after death.	Certification:	3 Suicide 6 Could not be determined			actory, office bu	uilding, etc.	or Town, S		Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire		29a. Certifier	n: To the best of my knowle		Lat the time da	te and place			
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner:	On the basis of examination	and/or investigation	, in my opinion,	death occurre	ed at the time, date	and place, and due to	the cause(s)
To wit	Me	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signed (M	fonth, Day, Year)
		Por O.	400.L		O.C.N	<b>Л</b> .Е.		August 16, 201	2
4	ŀ	30. Name and address of person who co			1		· · · · · · · · · · · · · · · · · · ·		
Y		Patricia Aronica-Pollak MD			00 W. Baltim	ore Street	, Baltimore, M	D 21223	
St Regis		31. Date filed (Month, Day, Year) AUG 2.7 2012	32. Registrar's Signa	ature					

**ORIGINAL** 

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug. Da 2012 William Samuel McDoniel 22, 0800 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Director 488-42-6536 70 1 XM 2 F Oct. 20, 1941 Missouri Usual Residence of Decedent or 28a-f show be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 3715 Eightpenny Lane 20716 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Africian 1 Tes 2 X No Specify. Completed 3X Widowed 4 ☐ Divorced Year or Dates.1960-76 American event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintence Tech Government Services is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vernon McDoniel Pauline Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Ellen Jones / Daughter 3715 Eightpenny Lane Bowie, MD 20716 other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/24/12 Woodbine, MD 21. Signature of Juneral Service Licensee Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Respiratory Failure disease or condition Medical resulting in death) **Examiner** Congestive Heart Failure Sequentially list conditions cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last **CVA** burial-tra Due to (or as a consequence of): physician the buria ician/Medical certificate be Division of Vital Records, P.O. Box 68760 nding pure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Pregnant at time of death the Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Completed 1 Yes 2 No 3 Probably 4 XUnknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} 2 🔀 No မှ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No after death. Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) under ss of person who completed c At1 ause of death (Item 23a) (Type, Print) Gebremedhin Yohannes M.D. 1500 Forest Glen Rd Silver Spring, MD 20910 31, Date filed (Month, Day, Year, 32. Registrar's Signature AUG 2 7 2012 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	aryland		rtment <i>tificate</i>				gien <b>e.</b> Reg. No.	UIZ	21204
H	Dhamist		1. Decedent's Name (First, Middle, Last,							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic		AMY	NESB	IT					AUGUS		2012	2215 PM
	Examin		4a. Facility Name (If not institution, give		,		4b. City, 1	Town, or	Location of Death	, .	4c. County of Death		
			1405 Potomac St						nore			N/A	
	Funeral		5. Social Security Number 6. Sec	7. A		ast birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	ı <i>y, Year)</i>	Cou	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		97	115.				5/11/	1915	SC	
	and w	1	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	f sho	ō	MD N/A		Pa	ltimo	ro						1 Yes 2 No
	the the 28a-	ect	10e. Street and Number		Ба	TCIMO	10f. Zip	Code		The state of the s	10g. Citiz	en of What Cou	ntry?
	with 3a or	0	1405 Potomac St	_				21:	213			USA	
	Jeath Te 23	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V	Was Deced	ent of His	spanic Origin? (Sp	ecify Yes or No	p- 1	4. Race - Ameri	
Ω.	or iter		1 Never Married 2 Married	Armed Forces	No				n, Mexican, Puerto	Hican, etc.)		Black, White, Specify: B1	
5	al', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2	No.	Specify:			Specify: B1	ack
ე- <u></u> ე	be filed within 72 hours after death with the Maryland its Hygiene. Its Hygiene. Other then "natural", or iteme 23a or 28a-f show other then "natural", or iteme 23a or 28a-f show event. The Medical Evaluation must be motified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	kind of wor.	k done d	uring most of work	ing	16b. Kin	d of Business/Ir	ndustry
7	ithin Jen.	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT us	e retired)	)				
2	ygier ygier ner th		6th	N/A		Seam	stre	SS	18. Mother's Name	Cimt Middle			Uniform
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last)  Baxter Blackmo	<b>n</b>								ourname)	
$\frac{8}{5}$	should ind Men marke umatic	P				40h Mailin		/Cam = 4 =	Lelia			Tour Chito 7	n Codo)
Ma	0 6 6 6		19a. Informant's Name/Relationship (7)										
	ss 1 and 2 should of Health and Mer litem 27 is marke r other treumatic		Robert Nesbit- 20a. Method of Disposition	2011	20b. P	lace of Dispo	sition (Nam	ne of		ILCIIIO Date	re 20c. Loc	ation - City or T	own, State
altimore,	Pages nent of int: if it iry or o		1 Burial 2 Cremation 3 F		C	emetery, cren	natory or of	her place		1/2012			
ᆵ	permit. Pages Department of Important: If it any injury or once.		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service Licens</li> </ul>		Ga.				nal 8/24	March			O., MD
Ba	permit. Pages Department of Important: If it any injury or once.		21. Signature of Current Convice Econs	i da	)								D 21202
			23a, Part1. Enter the disease, or complete	ications that cause	d the death							OLC, I	Approximate
			shock, or heart failure. List only o immediate Cause (Final			Α.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	DEME Due to (or a									SYEARL)
	Examiner			240 10 (0) 4	o a conseq.	aorioo oi).							
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	uence of):							
	outed ansit	Examiner	that initiated events										
Ó	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or a	s a consequ	uence of):							
8760	nte be nysici ne bu	dlcal		d									
9	ntifica ng ph as tl	Med	IF FEMALE:										
Вох	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth			Ectopic pr	egnancy			2	3d. Date of deliver Month	very Day Year
	that the death certificed by the attending of detached for use as	Physician/Me	1 Yes 2 No	4☐ Pregnant a 9☐ Unknown	at time of de	eath 5	Other (sp	ecify)					,
о. О	d by letach	Phy	Part II. Other significant conditions co	ntributing to death	but not rec	ulting in the u	nderlying c	ausa dive	an in Part I	23e. Did	tobacco u	se contribute to	the cause of death?
Ś	ires tha signed i be del	by	Part II. Other significant conditions co	ntributing to death	DUCTION 1830	uning in the di	ilderlying o	au30 g.ve	sit wit i date i.				bably 4 Unknown
oro	w require been si	etec								-			
Records,	has by	Completed								24a. Was		prior to c death?	topsy findings available ompletion of cause of
_										1 ☐ Yes	2 No	1 ☐ Yes	2 🗆 No
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of Deat				20
0	Q 5.	T.	1 Yes 2 No  27. Manner of Death	1 Inpat		ER/Outpatier 28b. Time of		8c. Injury	4 Nursing Ho	ome 5 ≤ es 28d. Describe		Other (Spec	erty)
uc	ding I h. After funer	tlon	1 ☑Natural 5 ☐ Pending	(Month, D	ay Year)	Injury	м -	Work					
Division	I or Attending after death. Director: After in by the fune	lica	3 Suicide 6 Could not be	28e. Place of Ir	niury - At ho	ome, farm, str				28f. Location	(Street and	d Number or Ru	ral Route Number,
<u>&gt;</u>	after Dire	Certification:	4  Homicide determined	building, e	etc. (Specify	y)	,			City or To	own, State,	)	
	spite ours nerei		29a. Certifier 1 Certifying Phy	sician: To the bes	t of my kno	wledge, deat	h occurred	at the tin	ne, date and place,	and due to the	cause(s)	and manner as	stated.
	• Ho • Fu • Fu	edical	(Check only 2 Medical Exam one)	ner: On the basis and manner s	of examina stated.	tion and/or in	vestigation	, in my of	pinion, death occur	red at the time	, date and	place, and due	to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	, 1	1		290	. License	e number		29d. Dat	e signed (Month	n, Day, Year)
			tentra	1non	h	MI		DG	2027		AUGU	50 21	2012
	O UL		30. Name and address of person who c	ompleted cause of	death (Item	n 23a) (Type,	Print)	0		I			
_	0 0.		JENNIFER HAYAS	SMT 55	505 -н	OPKTN	S RA	YUT	EW CIRC	-BA	LTO	MD 21	224
	Sta Regist		31. Date (1997) 20142	22. Regis	tras Signa	ares	,		-n cinc			,	- <b>-</b>
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2-06272 f JNK UNK	001	- li	State of Maryland / Departme	nt of Health and Mental Hy		ible. 2012 2726
			Registrar	te of Death	Reg	g. No.
Phys Medical Ex			VICTOR DE BEBOR TORTIBLO		2. Date of Death Month August 20,	Day Year 0635 hrs
			4a. Facility Name (if not institution, give street and number) 419 Scarsdale Road	4b. City, Town, or Location of Death Sparrows Point		4c. County of Death Baltimore County
Fune Direc			5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	yrs. If Under 1 Year If Under 24Hrs. Months Days Hours Min.		(MM/DD/YYYY) 9. Birthplace (State or Foreign 7,1985 EPount®ALVADOF
2			Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	<b>E</b>	<u>_</u>	MD BALTIMORE BA	LTIMORE		1 Yes 2 X No
Maryland	notified at once.	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Country?
ith the	notific		419 SCARSDALE ROAD  11. Marital Status  12. Was Decedent Ever in U.S.  11. Marital Status	21224		EL SALVADOR
eath w	ust be	Funeral	11. Marital Status  1 Never Married 2 Married 2 Armed Forces?  1 Yes 2 X No	<ol><li>Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri</li></ol>	city Yes or No- ican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
after d	incr	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specifySALV		Specify: WHITE
2 hours	Exam			cedent's Usual Occupation (Give kind of wor ring most of working life, DO NOT use retired		16b. Kind of Business/Industry
036 ithin 72 me.	Tedica	Completed	3	LABORER	ĺ	RESTAURANT
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	t, the		17. Father's Name (First, Middle, Last)	18. Mother's Name (F		
212 212 ould be Menta	c even	To Be	VICTOR DE JESUS PORTILLO, SI  19a. Informant's Name/Relationship (Type, Print)  19b. 1	R MARIA  Mailing Address (Street and Number or Rur	CATAI	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-false	traumatic event, the Medical Examiner		MARIA PORTILLO/MOTHER 550	) <del>49</del> th STREET, BAL	TIMORE	E, MARYLAND 21224
Ore, es l an of Hea If ite	ther tr		1 K Burial 2 Cremation 3 Removal from State crematory	or other place)		20c. Location - City or Town, State
Baltimore, permit. Pages 1 ar Department of Het (mportant: If ite	y or o		4 Donation 5 Other Specify:  21. Signature of Exercial Service Licensee	IPAL DE SESORI 9/		SESORI, SAN MIGUE
Dept.			I touch	22 Lardaddarss of Eillur 1901 EASTERN AV	INC. F ENUE, E	'UNERAL HOME BALTIMORE,MD 21231
Physicia /Medic			23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	nter the mode of dying, such as cardiac or re	espiratory arres	t, shock, or heart Approximate Interval Between Onset and
Examin			Immediate Cause (Final disease or condition resulting in death)  a Multiple Sharp Force Injuries  Due to (or as a consequence of):			Death
			Sequentially list conditions, b			
		Examiner	if any, leading to immediate cause Enter Inderlyin; Cause (Disease or injury that initiated			
sand cecuted	- transit	Exa	events resulting in death) Last  Due to (or as a consequence of):			
se executed		dical	UNPENDED X AMENDED 19b per fh	g931 9-7-12 vt		
Box 68760, death certificate be the attending physic	or use as the burial		IF FEMALE: 23b. Was decedent pregnant in the	Fetal death 3 Ectopic pregnancy		23d. Date of delivery
ox 68 ath certi	or use a	icia Sicia	past 12 months?  4 Pregnant at time of death	Fetal death 3 Ectopic pregnance Other (Specify)	y 	Month Day Year
O. BC t the dez by the z	8		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e Did toba	acco use contribute to the cause of death?
i, P.O.	e det	ð Š				2 No 3 Probably 4 ✔ Unknown
ords w requi	should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Recol The law	page 2	틹			perform	
ital Rediction: The s certificate	ector	8	25. Was case referred to medical examiner?  Hospital:   Inpatient 2 FR/Output	26.Place of Death (Check only		
Of Vi ing Physi After this	funeral d	읽	1 Yes 2 No 27. Manner of Death 28a Date of Injury 28b Tim	e of Injury 28c. Injury at Work? 28	d. Describe hov	esidence 6 🗹 Other: Scene v injury occurred
sion ttendir death.	y the fu	ä	1 Natural 5 Pending FOUND: Day, Year) FOUND Accident Investigation FOUND Aug 20, 2012 0621 hr	' I 1   Yes 2 V No I	ıbject assau	lited
Division of Vital Records,  Hospital or Attending Physician: The law require 24 hours after death.  Funeral Director: After this certificate has been si	ed in b	Certification:	3 Suicide 6 Could not be determined (Specific Posts Po		or Town, Stat	eet and Number or Rural Route Number, City e) Road, Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician.	completely filled in by	ल	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of one)  2 Medical Examiner: On the basis of examination and/or inve	occurred at the time, date and place, and due	e to the cause(s	s) and manner as stated
To wit	con	ĕ	and manner stated.  29b. Signature and title of certifier	29c. License number		9d. Date signed (Month, Day, Year)
		-	Theodor My King JRu ween	O.C.M.E. 00	ME /	August 21, 2012
2		1	30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examine	er 900 W. Baltimore Street, Balti	imore MD 2	21223
			31. Date filed (Month, Day Year) 32. Registrar's Signature	230 TT DELIMINATO OLIGOT, DELI		. 1220
Reg	istr	ar	AUG 2 7 2012 Denur A. gares			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 27266

			1- For State Registrar	Ce	rtificate of	Death	ila iviolita	R R	eg. No.	12 2120
Phys Medical Exa			1. Decedent's Name (First, Middle,Last)	2 70				2. Date of Dea Month	th Day Year	3. Time of Death
Medical Exe	allill	ier	Juan Aried  4a. Facility Name (if not institution, give street and number			4b. City, Town, o	or Location of I	August 19	9, 2012 4c. County of De	0727 hrs
			Prince George's Hospital Center	• /		Cheverly	or Location of	Dodai	Prince Geor	
Fune	rai		5. Social Security Number 6. Sex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Ye			th(MM/DD/YYYY) 9.	Birthplace (State or
Direct	tor		577-31-9638 1X M 2 F Usual Residence of Decedent	2	.6 Yrs	Months Da	ys Hours	May (	12,1986	eign Pominican Country Republic
Any			10a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
Maryland 28a-f show	nce.	ь	Maryland Montgomery			S	ilver.	Spring		1 Yes 2 No
Maryl	d at c	Director	10e. Street and Number		•	10f. Zip Code			0g. Citizen of What Co	ountry?
ith the 1	be notified at once	圁	13015 Morningside Lane		0 I 10 111		20904			.S.A.
e, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural?, or items 23a or 28a-fabe	ust be	Iner	1 X Never Married 2 Married Armed Forces	3?				? (Specify Yes or No uerto Rican, etc.)	- 14. Race - Am White, etc.	erican Indian, Black,
after d	ner m	DY F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	2 X No	1 <b>X</b>	Yes 2 N	o specify:	Other	Specify: H	ispanic
hours a	xami		15. Decedent's Education (Specify only highest grade co			's Usual Occup			16b. Kind of Busines	s/Industry
MD 21215-0036 2 should be filed within 72 h h and Mental Hygiene. 27 is marked other than ",	event, the Medical Ex	Completed	Elementary/Secondary (0-12) College (1-4 or	5+)	_	ctional			Law End	orcement
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	ne Me	튅	17. Father's Name (First, Middle, Last)		CONDIE	.c.com		Name (First, Middle, I		recement
215 be file ntal H	ent, tl	Be	Juan Jose I	ena .				Maria	Antonia B	vre
2 21 should nd Me	#	의	19a. Informant's Name/Relationship (Type, Print )						nber, City or Town, Sta	
ore, MD s 1 and 2 sho of Health and If item 27 is	raum	ŀ	Juan Jose Pena - Father  20a. Method of Disposition	20h J	13015 Place of Disposi			Ln., Silve	Spring, MI 20c. Location - City	
Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27	other traumatie		1 X Burial 2 Cremation 3 Removal from S	tate	crematory or oth	er place)				
Baltimor permit. Pages Department of Important: If	ry or	ŀ	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee /	Geo	rge was	nungton	s of Facility L	08/25/2012	Adelphi,	Maryland l Home, Inc.
Day Depx	iji	1	Millinganellur		1118	00 New	Hampsh	ire Ave., S	Silver Spr	ing, MD 20904
Physicia // /Medic			23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line.	d the death.	. Do not enter th	e mode of dying	g, such as card	diac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examin			Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injurie  Due to (or as a constitution)		F).					Death
	۱		Sequentially list conditions, b.	sequence ()	1).					
		je	if any, leading to immediate Due to (or as a con: cause. Enter Underlying Cause	sequence of	F):		-			
_	, E	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a cons	sequence of	f):					
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and	- trans	- 1	d			<del>-</del>		<u>-</u>		
<b>760,</b> cate be execut physician and	burial	Medical	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome and the second						Too to the	
5876 rtifica ling ph	use as the		23b. Was decedent pregnant in the past 12 months?		2 Fet	al death 3	Ectopic pr	regnancy	23d. Date of delive Month	Day Year
Box 68's death certiff	for use	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	t time of dea	ath 5 Oth	er (Specify)			1	1
or the de	ached		Part II. Other significant conditions contributing to dea	th but not re	esulting in the ur	nderlying cause	given in Part I	. 23e. Did to	bacco use contribute t	o the cause of death?
ires that the signed by	be de	ğ Q						1 Yes	2 🗸 No 3 🗌 Pr	obably 4 Unknown
of Vital Records, g Physician: The law requir ther this certificate has been si	should	Completed						24a. Was a		autopsy findings available completion of cause of
<b>Reco</b> The law	page 2	Ē						perfor 1 <b>✓</b> Yes 2		
tal Recision: The certificate		Be .	25. Was case referred to medical examiner?				e of Death (Ch			
Physic er this	Tal di	의	1 ✓ Yes 2 No Inspire. 1 Inpati 27. Manner of Death 28a. Date of Inj		ER/Outpatient 28b. Time of In		Other Nury at Work?		Residence 6 Oth	er:
On O nding nth.	e fune	Certification:	1 Natural 5 Pending Aug 19, 201	Year) 2	0638 hrs		Yes 2. ✔ No	Operator of	motorcycle involv	ved in collision
Division tal or Attendirs after death.	n by th	<u>ड</u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of I	njury - At ho	me, farm, street	, factory, office	building, etc.	28f. Location (S	treet and Number or F	Rural Route Number, City
DIVISION  Hospital or Attend  24 hours after death  Funeral Director:	filled in		4 Homicide determined (Specify) Lo	cal Stree	et			or Town, St Fenway Lane	tate) and Brown Station I	Rd, Upper Marlboro, M
n 24 h			29a. Certifier (Check only one)  2 Medical Examiner: On the basis of e							
To the within 2	com	<u>8</u> L	one)  2 Medical Examiner: On the basis of examiner and manner stated 29b. Signature and title of certifier	auon ar	id/of investigation	29c. Licen:		red at tile time, date a	29d. Date signed (M	
	-   '	_	Pt 1 DOO				M.E.		August 20, 201	
		-	30. Name and address of person who completed cause of	death (Item	23a)					
MV			Patricia Aronica-Pollak MD. Assistant N	/ledical E	Examiner 9	900 W. Balti	more Stree	et, Baltimore, MD	21223	
Reg			31. Date filed (Month, Day, Year) 32. Registra	ar's Signatu	arkel					

OCSAE

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sterling Parker		1- For State Registrar	State	of Maryland		artment of rtificate of		nd Mer	ntal Hygiene	Reg. No	201	2	2726
Physic Medical Exam		1. Decedent's Name Sterling		•					2. Date of D Month	eath Day	Year	3. Time o	
g#11		4a. Facility Name (if	not institution, give			41	b. City, Town,	or Location	August 2		12 4c. County of Deat		1113
F		University H 5. Social Security N			/1- · · · ·		Baltimore	Torre .					
Funeral Director		217–52–7  Usual Residence of	797 1D	M 2 F	Age (In yrs. I:	Yrs.	If Under 1 Ye Months Da	ays Hour			M/DD/YYYY) 9. Bi. Foreig	gn ountry)	MD
any			10b. County		10c. City,	Town or Locatio	n					10d. Insid	de City Limits
rland -f show	ᅙ	MD	n/a				timore			_		1 X Ye	es 2 No
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	al Director	10e. Street and Num 1908 Wall						21217		US			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health, and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a, or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	1 Never Marrie 3 Widowed		1 Yes If Yes, Give Year		If Yes	Decedent of H s, specify Cuba Yes 2 x N	an, Mexicar	igin? (Specify Yes or the Puerto Rican, etc.)	No-	14. Race - Amer White, etc.		, Black,
nours al natural	ed by	15. Decedent's Edi		l or Dates: nly highest grade co	ompleted)	16a. Decedent's	Usual Occup	ation (Give	kind of work done	16b.	Specify: Bla Kind of Business/		
36 in 72 } han "r dical E	Completed	Elementary/Secon	ndary (0-12)	College (1-4 o	r 5+)	during mos	of working lif	e. DO NOT	use retired)				
5-00 ed with tygien other	Сош	17. Father's Name (F	irst, Middle, Last)				Cook	18.Mother	r's Name (First, Middle		ood Serv	<u>rce</u>	·
121 d be fil fental B	Be C	Robert Et				Lagina			ne Delores				
MD 21215-0036 d 2 should be filed within 7 ith and Mental Hygene. n 27 is marked other than numatic event, the Medical	To	Sharon Pa							mber or Rural Route No nue Baltima				
Ore, I		20a. Method of Dispo	_	Removal from S	state c	Place of Dispositi rematory or othe	on (Name of ce r place)		Date	20c.	Location - City or	Town, Stat	e
Baltimore, permit. Pages I an Department of Hee Important: If ite		4 Donation 5 21. Signature of Fundamental	Other Specify: eral Service Ligen	sep- 1 1	Cre	emation 22. Na		s of Facility	08.29.201		anover,	MD	
		IMM	1.1		m	1 451	/ Hank He	PIGNES	AMEDIA RAITI		. MD 21215		
Physician /Medical Examiner		failure. List only Immediate Cause (F or condition resulting	one cause on ea inal disease a.	ch line. Head Injuries v	vith Comp	olications	mode of dying	j, such as c	ardiac or respiratory a	rrest, sh	ock, or heart	Between	mate Interval n Onset and Death
	J	Sequentially list cond	ditions, b.	Due to (or as a con									
_	edical Examine	if any, leading to imm cause. Enter Under! (Disease or injury that	ying Cause at initiated c.	Due to (or as a con:									
iO, e be executed ysician and burial - transit	Exa	events resulting in de	eath) Last dd.	Due to (or as a cons	sequence of	):							
6 be exe ysician a burial -	dica	UNPENDED		AMENDED									
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	ΣI	IF FEMALE: 23b. Was decedent pr past 12 months?		1 '=	ome of pregn	2 Fetal	death 3	Ectopic	pregnancy	23	d. Date of delivery Month D	ay	Year
P.O. Be that the de ned by the detached fi		Part II. Other signific		9 Unknown contributing to dea	th but not re	sulting in the und	lerlying cause	given in Pa	art I, 23e. Did	tobacco	use contribute to t	the cause c	f death?
ires that the signed by	d by										No 3 Prob		
of Vital Records, ng Physician: The law require the this certificate has been sinneral director, page 2 should be	Completed								24a. Was auto perfo	psy orm <u>ed</u> ?	death?	ompletion o	
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred examiner?		ospital: 1 🗸 Inpati					(Check only one)				
ing Physical After this funeral dir	앍	1 ✓ Yes 2 27. Manner of Death	No	28a. Date of Ini	urv :	ER/Outpatient 3 28b. Time of Inju		Other <sub>4</sub>	Nursing Home 5 28d. Describe		ence 6 Other:		
	ation	1 Natural 2 Accident	5 Pending Investigatio	Aug 4, 2012	Year)	0000 hrs		Yes 2	Subject acc				
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Certification:	4  Homicide	Could not be determined	(Specify) res	sidence	ne, farm, street, f			or Town, 1908 Walbro	State) ok Ave	nd Number or Rur nue, Baltimore,	MD	umber, City
To the Hos within 24 h To the Fur completely	edica	(Check only one) 2 M	edical Examiner:	n: To the best of m On the basis of exa and manner stated.	ny knowledge Imination and	e, death occurred d/or investigation	, in my opinion	n, death occ	ce, and due to the cau curred at the time, date	se(s) an and pla	d manner as state	d. : cause(s)	
	2	29b. Signature and tit	e or certifier				29c. Licens				Date signed <i>(Mon</i> ust 21, 2012	th, Day, Yea	ir)
		30. Name and address Donna M. Vin		ompleted cause of d	•	,	. Baltimore	Street,	Baltimore, MD 21	1223			
Sta Regist		31. Date filed (Month,		32. Registra	n's Signature								
DHMH 17 Rev 1/20	_	AUG 2	7 2012	OCAAE.	A. 1	ORIGINAL							
OCME 2006				OGME		UNIGHAL							

				Pleas	se Type or					-		•	
			For State Registrar		State o	of Maryla		artment of tificate of		d Mental Hy	/giene Reg. No	201	2 27268
	Physicia Medic		1. Decedent's Nam							2. Date of Do Month 8	eath Day 25	y Year 2012	3. Time of Death 4:21 A <sup>M</sup>
	Examin		4a. Facility Name (ii Suburba			nber)		4b. City, Town, Bethe	or Location of De	ath	4c. County of Death  Montgomery		
	Funeral Director		5. Social Security N 578-24-8	lumber 8466	6. Sex 1 □ <b>X</b> M 2 □ F	7. Age ( <i>In yr</i> s	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		rth a <i>y</i> , <i>Year)</i>	9. Bir Co	thplace (State or Foreign untry) hington, DC
	aryland a-f show fied at	Director	Usual Residence  10a. State  MD	of Decedent  10b. County  Montgo	omerv		City, Town or Lo	cation					10d. Inside City Limits 1X Yes 2 □ No
	ith the Ma 3a or 28 it be noti	ral Dire	10e. Street and Nu	mber				10f. Zip Code				izen of What Co	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	d by Funeral	9209 Bet 11. Marital Status 1 Never Mari	ried 2 Marrie	12. Was Dece Armed Fo			20854 Was Decedent of I f Yes, specify Cub	Hispanic Origin? oan, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		ted Sta 14. Race - Ame Black, Whit Specify: Wh	rican Indian, e, etc.
21215-0036	hin 72 hours ne. <b>than "natur</b> e <b>Medical E</b>	Completed		15. Decedent ecify only highes	's Education t grade completed, College (1		(Give life. D	dent's Usual Occu kind of work done O NOT use retired	during most of w	vorking	}	ind of Business	
land 2	be filed wit ental Hygier ked other ic event, th	To Be C	17. Father's Name				Busi	ness Own	18. Mother's N	Name (First, Middle K. Kirst	, Maiden :	Food Se Surname)	rvice
e, Maryland	and 2 should lealth and M im 27 is mar her traumat		19a. Informant's N	senthal			38 Ma	ryland A	and Number or	Rural Route Numb	er, City or	le, Mar	yland 20850
Baltimore,	nit. Page 1 a artment of H ortant: If ite injury or ot		4 Donation	☐ Cremation 3 5 ☐ Other (Sp		State Ga	rden of	sition (Name of matory or other place Remembrance). Name and Addr	ance 8-		Cla	rksburg -Go1dbe	, Maryland
Ba	permi Depar Impor any ir		21. Signature of Fu	7	tee_		1	170 Rock	ville P	ike, Rocl	cvill		1and 20852
	h sician/ Medical Examiner		23a. Part 1. Enter shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List on (Final	ly one cause on ear Acut a. Due to	e Pulm (or as a conse	onary E	dema		lac or respiratory a	rrest,	//2	Approximate Interval Between Onset and Death
	be executed cian and burial-transit	al Examiner	Sequentially list or it any, learning to it cause. Enter Unde Cause (Disease or that initiated event resulting in death)	erlying injury	Chro	or as a curse	ronary	Infarcti Atery Di				3	
. Box 68760	The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 1  Yes 2 9  Unknown	months?		Birth 2 Fe nant at time o	etal death 3	Ectopic pregnar	ncy			23d. Date of de Month	livery Day Year
ds, P.O.	requires that the been signed by should be deta		Part II. Other signi		s contributing to d		esulting in the u	ınderlying cause ç	liven in Part I.				the cause of death?
		Completed by	25 W-							perf 1 🗆 Yes	opsy formed?	prior to death?	topsy findings available completion of cause of
n of Vita	ling Phys .r. After this i	cate: To Be	25. Was case referr examiner?  1 Yes 2  27. Manner of Deat  1 Natural 2 Accident	X No	28a. Date (Mon		ER/Outpatier 28b. Time of injury	nt 3 DOA Oti	ry at	g Home 5 Res			ify)
Division	i di di	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6  Could no determin	ot be 28e. Place	of Injury - At I		eet, factory, office			(Street and wn, State)		ral Route Number,
	To the Hospital within 24 hours: To the Funeral I completely filled	Medical	(Check 2	Medical Ex	Physician: To the base aminer: On the base Nurse Practitioner	sis of examinat	ion and/or inves	tigation, in my opir	ion, death occurre the time, date an	ed at the time, date	and place the cause	, and due to the	cause(s) and manner stated. as stated.
9	10an		30. Name and addr	Ull G	1/2	Ty 2	23a) (Time 5	D071				25-2012	-,,/
	, W.				./	- 860	0 01d 0	*	vn Road,	Bethesda	a, Ma	ryland	20814
	Sta Registra		AUG 27	2012"/	Zeneva 32. H	egi trar's Si	tike						

12-06231 Marquest Rollins		Ple	ease Type o	r <b>Print in</b> I of Marylan						egible		2 2726
	B	- For State tegistrar			•	ificate c				Reg. No.	201	2 2726
Physician Medical Examine	er	Marque	e (First, Middle,Last est Roll	ins					2. Date of D Month August	Day 18, 2012	Year	3. Time of Death 1952 hrs
	1	ta. Facility Name (i Sinai Hospit	if not institution, give tal	street and numb	er)		4b. City, Town, of Baltimore	or Location of D	eath	4c.	County of Deat	h
Funeral Director		5. Social Security N			Age (In yrs. las		If Under 1 Ye		Min.	•	DD/YYYY) 9. Bi Forei	
		Jsual Residence of	90	M 2 F		35_Yr	s.		1.5/1	7/19	77	ountry) MD
ne Maryland or 28a-f show any fied at once.	ĺ	I 0a. State	10b. County			own or Loca						10d. Inside City Limits 1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at once		MD  Oe. Street and Nur	N/A mber		Bal	timor	10f. Zip Code			10g. Citiz	en of What Cou	
h the M 3a or 2			estheig	hts Rd.	•		212	15		Ŭ.	SA	
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f shour other traumatic event, the Medical Examiner must be notified at once.  To Re Commission by European Disperse.	Tiera	11. Marital Status 1 X Never Marrie	ed 2 Married	12. Was Decede			as Decedent of H Yes, specify Cuba		( Specify Yes or erto Rican, etc.)	No-	14. Race - Amei White, etc.	rican Indian, Black,
rafter de		3 Widowed	4 Divorced	or Dates:		1		o s <i>pecify</i> :			Specify: Bl	
2 hours "natur	Completed by	15. Decedent's Ed Elementary/Seco	ducation (Specify on andary (0-12)	ly highest grade of College (1-4			nt's Usual Occup nost of working lif			16b. Ki	ind of Business	Industry
5-0036 led within 7/ Tygiene. other than		12t		N/A	,	Ι	isable	d		N.	/A	
MD 21215-0036 d 2 should be filed within 7 ith and Mental Hygiene. n 27 marked other than numatic event, the Medica	2 1		(First, Middle, Last)	ine					ame (First, Middle		Surname)	
ould be d Menti	2 1		me/Relationship (Ty			19b. Mailin	g Address (Stre		ie John or Rural Route N		y or Town, State	e, Zip Code)
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withis Department of Health and Mental Hygiene, Impurtant: If item 27 is marked other th injury are other traumatic event, the Med		Valerie	Rollin	s-Mothe	er Tanh Pla		Crest		s Rd	3alt:	imore, ocation - City or	MD 21215
Baltimore, permit. Pages I ar Department of Hee Impurtant: Uffer Injury or other tr		1 Burial 2	Cremation 3	Removal from	State cre	ematory or o	ther place)					
Baltin permit. P Departme Impurtan injury ar	2		Other Specify: neral Service Licens	see /	On	S1 te	Name and Address	tory 8 ss of Facility	/25/20 March		<u>altimo</u> - East	re, MD
	4	3a Part I Errer th	e disease, or compl	mes inations that caus	ed the death C	11	01 E.	North	Ave. Ba	altir	more,	MD 21202 Approximate Interval
Physician /Medical		failure, List onl	ly one cause on ea	n line. Hyperten								Between Onset and Death
Examiner		or condition resulting		Oue to (or as a co			01010010	, our uzu	Vaboura			
Je v		Sequentially list cor f any, leading to im cause. Enter Unde	mediate [	Oue to (or as a co	nsequence of):							
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OKerd	3	<ol> <li>Name and address</li> <li>Jack Titus M</li> </ol>	ess of person who co ID. Deputy C	mpleted cause o			Baltimore Str	eet, Baltimo	re, MD 2122	3		
State	e <sup>3</sup>	1. Date filed (Monti			s Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Laura Ratliff 40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Frederick Villa Nursing and Rehabilitation Baltimore Catonsville, MD 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 96 217098523 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 ☐ Yes 2 No Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be flied within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ပ္ Daughter, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, cr Burial 2 Cremation 3 Removal from State Garaen 4 Donation 5 Other (Specify) Sign of Funeral Service Lice Home 2 21 h 23a. Pay 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ advanced disease or condition Medical resulting in death) Examiner vaicular disease Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events to for as a consequence of attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? Day Month Year Pregnant at time of death 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 1 No death? within 24 hours after death.

To the Funeral Director; After this certificate 1 🗌 Yes 2 🗆 No funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 **N**o 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Ecertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) triend R147*65*8 7-201

Registrar

State

711 Academy Road Catanville IMD 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

haria Friend

AUG 2 7 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ August 22, 2012 0800 a M Jacqueline Egerton Schlueter Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard 10358 Derby Drive Laurel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Apr 13, Days Min <sup>re</sup>1960 Director Maryland 218-48-3327 1 🗆 M 2 🔀 F 52 Yrs Usual Residence of Dece 10a, State within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Howard Laurel 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 20723 USA 10358 Derby Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 St Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ottany prigury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Griswold Egerton Jacqueline Fay Mahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Schlueter / husband 10358 Derby Drive Laurel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/25/12 Woodbine, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01651 Beverly L. Heckrotte, P.A. MD 21029 Clarksville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LENKEMIA Physician/ ACUTE MYELO 10 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SUNDROME 2 YEARS MYELODYSPLYSTZ Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence or): Physician: The law requires that the death certificate be executed use as the burial-trar ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day a | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s autopsy performed? Yes 2 AN death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 XNo 유 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. te Funeral Director: After th Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0057005 Avgust 23,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Mamland 1650 Orleans Street Carrawan 31. Date filed (Adonth, Day, Year) AUG 2 7 2012 32. Registrar's Signatur Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 2012 CLAIRE SPREJREGEN 3:16 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TUDOR HEIGHTS ASSISTED LIVING BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Months Days Hours Min (Month, Day, 07/14/ Director 048-14-8287 86 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director 1 XYes 2 No MD N/A BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 7218 PARK HEIGHTS AVENUE 21208 items 2 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ♣ No Black, White, etc. ò þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Year or Dates Specify. "natural", 3 ☑ Widowed 4 ☐ Divorced Completed WHITE traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 BOOKKEEPER RETAIL Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 AARON STEINMAN SADIE FEINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON FREEDMAN/DAUGHTER 2905 FALLSTAFF ROAD, #33, BALTIMORE, MD 21209 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 □ Cremation 3 🕅 Removal from State injury o Donation 5 Other (Specify BROTHERS OF JOSEPH 08/26/2012 NORWICH, CT of Fun ral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. any 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or comp ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only of Immediate Cause (Final Onset and Death Pnysician ongestive disease or condition resulting in death) Medical Due to (or as a xx sequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the bunal-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown detached g Unknown Division of Vital Records, P.O. þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been siç page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Tes 2 🗌 No filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 C Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t or Attending 1.XNatural injury work?
1 Yes 2 No 5 Pending within 24 hours after death.

To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one 29b. Signature and title of certifier 29c. License number

State Registrar LUUVZ

N. Char

AIIC 2

31. Date filed (Month Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Anne Lewis, CRNP

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			For	State of Ma	aryland / Depa			1ental Hy	giene		
			State Registrar	( oot)	Cer	tificate of De	eath		Reg. No. 2	)   2	27273
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)	Medic Examin		4a. Facility Name (if not institution, University of Man	give street and number)	Center	4b. City, Town, or La		08	4c. County		
1	Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	18 M 2 □ F	7rs.			11-13.			th Cordina
	yland f shov ed at	tor	10a. State 10b. County		10c. City, Town or Lo					11	0d. Inside City Limits
	r 28a- r 28a- notifie	Direc	10e. Street and Number		- BAlti	10f. Zip Code			40.000		1 🔀 Yes 2 🗌 No
	with th 23a o ust be	Funeral Director	1127 Nant	core s	1	21239	6		10g. Citizen of V		try?
	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent E Armed Forces?		Vas Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race	e - America k, White, e	
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/lan	Ild be fill Mental larked o	오	lawpence	. wasken	-		Elizat		Burge	,	
Maryland	should n and Me		19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street and					
	and 2 Health tem 23		Quencial YY 20a. Method of Disposition	n walkers	wife 1127 20b. Place of Dispo			Date	20c. Location -		15 21 230
Baltimore,	0		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		cemetery, cren	natory or other place)			Bathe		
alti	permit. Page Department Important; If any injury or once.		21. Signature of Funeral Service L		10	. Name and Address		0			orgina.
	9 9 5 % 9		James	2. Jan	Ch		Fulleral	Home	1000	wish	en notenin
ı	DESCRIPTION OF THE PERSON OF T		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final			•			est,		Approximate Interval Between Onset and Death
	Ph, i. i Medical		disease or condition resulting in death)	a. Decor	con quence of):	ed liver	tail!	<u>_</u>			
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	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence oi).						
	be executed sician and burial-transi	Еха	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):						
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189	certificate inding physuse as the	/Me	IF FEMALE:	220 If yes systems	of programme and						
Rox	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of Live Birth	2 🗌 Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive nth	ry Day Year
	the de by the tached	hysi	9 Unknown	9 🗆 Unknown							
у. О.	The law requires that the ate has been signed by the page 2 should be detach		Part II. Other significant condition	ns contributing to death be	ut not resulting in the u	nderlying cause giver	n in Part I.				e cause of death?
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Division of Vital Records,	sician: The law certificate has rector, page 2	Be Co	25. Was case referred to medical	1		26. Place	e of Death (Check		rmed?	Yes	2  No
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n o	ding P h. After t funera	ate:	27. Manner of Death  1 ★ Natural 5 □ Pendin		y 28b. Time of injury	28c. Injury a work?		28d. Describe h	ow injury occurre	ed	
SIOI	Attendar death	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Inju	ry - At home, farm, stre		es 2 🗆 No	28f. Location (S	treet and Number	er or Rural	Route Number.
2	tal or rs afte al Dire		4 - Hornicide determin	building, etc	(Specify)			City or Tow	n, State)		<i>'</i>
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical	(Check 2 L Medical E	Physician: To the best of a xaminer: On the basis of ex	amination and/or invest	igation, in my opinion,	death occurred at	the time, date a	nd place, and due	to the cau	se(s) and manner stated.
	Fo the vithin somple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practitioner: To the	best of my knowledge,	death occurred at the 29c. License n			he cause(s) and m 29d. Date signed		
			· MAL	MD		1780	909242	2	Augus	7.3	2012
			30. Name and address of person of Randi Kestler	who completed cause of de	eath (Item 23a) (Type, F	Print)	- باطاء	manl	a. d. 71	201	
	Sta	e	31. Date filed (Month, Day, Year)		r's Signature	True 18	ald shook	11104]	mra Cl	201	
	Registra		AUG 2 7 2012	( seek	r's Signature						
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 1 2

		Registrar  1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
Physicia /Medic	an al	George F. U 4a. Facility Name (If not institution, give stree	Nalters, SR		Month 8	Day Year	7100 M
Examin	er	4a. Facility Name (If not institution, give street	t and number)	4b. City, Town, or Location of Dea	th	4c. County of Dea	
		Future Case Car  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Baltmore  y) If Under 1 Year If Under 24 Hr:	8. Date of Birth		HMORE CH rthplace (State or Foreign )
Funeral Director		2/9-/8-4535		Months Days Hours Min	Month, Day,	year) 9. Bi	Country) MD
show		10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits
r 28a-f show	ctor	MD	Balt	more City			1 ☐ Yes 2 ☐ No
with the Maryland e or 28a-f show	Director	10e. Street and Number	01 1 10 11	10f. Zip Code	10	g. Citizen of What C	Country?
E 23	Funeral	603 S. UNN 11. Marital Status 12.	Vas Decedent Ever in U.S. 13	3 Was Decedent of Hispanic Origin?	Specify Yes or No-	USA 14. Race - Am	rerican Indian,
ē ± 5	by Fun	1 □ Never Married 2 □ Married	Amed Forces?  Yes 2 No f Yes, Give fear or Dates:	3. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue)  1 Yes 2 No Specify:	rto Rican, etc.)	Specify:	ite, etc.
72 hours at natural', or	ted	15. Decedent's Education (Specify only highest grade co	in 16a. Dec	cedent's Usual Occupation	orkina	16b. Kind of Busines	s/Industry
nin e	Completed		College (1-4or 5+)	ve kind of work done during most of wi . DO NOT use retired)	,,,,,,,	1	1 1/1-00
pe // 1	Co	17. Father's Name (First, Middle, Last)		SuperVISOR 18 Mother's No.	ame (First, Middle, M	MENER RIMATION	MOTORS
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d 2 should by the and Menta? Is marked treumatic events of the contraction of the contrac	으	19a. Info 's Name/Relationship (Type,	Print) 19b. Ma	illing Address (Street and Number or F	1,3	City or Town, State,	Zip Code)
		JOANNE Siemek	- NICCE 79	959 EASTOWNE	Cd. Ball	HINORE, 1.	XD 21224
mit. Pages 1 and partment of Healt portant: If item 2 y injury or other <u>ce</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo	comotoni ci	position (Name of rematory or other place)	Date	20c. Location - City o	or Town, State
Pag Iment tant: I		' 4 ☐ Donation 5 ☐ Other (Specify)	Dayvieu		23/2012	Dalhore	re, MD
permit. Depart Import any inj		21. Signature of Funeral Service Licensee	/	22. Name and Address of Facility	Bradley		Funeral
TOPEG		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as the complex of the com	ons that caused the death. Do not e	PH 2 134	ac or respiratory arre		Approximate
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		nsihonal Cell co			Interval Between Onset and Death
p #	ner	Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence of):				
be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
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tificate be exigonate physician as the buria	edicat	d					
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months?		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of d Month	lelivery Day Year
that the	y Ph	Part II. Other significant conditions contrib	uting to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
quires quires n signe	q pa				1 □ Ye	es 2. <b>∑</b> (No. 3. ∏.	Probably 4 Unknown
sicien: The taw requires ti certificate has been signe rector, page 2 should be c	Completed				24a. Was a autops		autopsy findings available o completion of cause of
The tav	om				perform	ned? death	?
ysicien: The is certificate hadirector, page	Be C	25. Was case referred to medical examiner?		15.00 - 10.00 - 10.00	eath (Check only on	e)	
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ding F h. After funera	lon	1 Natural 5 ☐ Pending	8a. Date of Injury (Month, Day Year) 28b. Time		280. Describe no	w injury occurred	
or Attending Physicien: after death. Director: After this certifica in by the funeral director.	Certification:	3 Suicide 6 Could not be	8e. Place of Injury - At home, farm,				Rural Route Number,
al or / after Dire	erti	4  Homicide	building, etc. (Specify)		City or Town	n, State)	
To the Hospital or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Medical C		C that well of manufaction on the	eath occurred at the time, date and pla investigation, in my opinion, death oc	المراجعة والمرافع والمسادين	ata and alasa and d	un to the course(s)
To th To th comp	Me	29b. Signature and title of certifier	0 44 5	29c. License number	2	9d. Date signed (Mo	nth, Day, Year)
		Karen Dona	Low Min	D006167	+	8/22/	112
		30. Name and address of person who comp	eted cause of death (Item 23a) (Typ	29c. License number  DUD6167  De, Print)  Callhway Drve	Rech.	140 71	811
	i	KAREN DONALDSON	14,0, 8115 Me	alloway prive	wo IIn	1 00 01	~ / /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene StateRegistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 1504 Рм Robert Raeford Adkins, Sr. August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 35 Deer Run Parkway Cecil E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral av 21, 1938 Months Days Hours Maryland Director 214-36-8606 74 May Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director must be notified 28a-f 1 Yes 2 X No Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 'n 10g. Citizen of What Country? Funeral death with 23a35 Deer Run Parkway 21921 United States Department of Health and Mental Hygiene. Important: if Nem 27 is marked other than "natural", or items, any injury or other traumatic event, the Medical Examiner muone. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?
1 X Yes 2 Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 X Married 2 🗌 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Lemon Clyde Adkins Margaret Elizabeth Gathings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean T. Adkins/Wife 35 Deer Run Parkway, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State August 4 □ Donation 5 🗓 Other (Specify) Entombrent Harford Memorial Gardens Aberdeen, MD 2012 21. Signature of Funeral Service Licensee Hicks Home for Funerals, 22. Name and Address of Facility 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or impury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year Yes 2 ☐ No g | Unknown 9 Unknown signed by t Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should be Completed 1 Yes 2 No 3 Probably 4 Number 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No Hospital မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nuxse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062190 16/12 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ KHAN MD 2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKECITY

Registrar

State

31. Date filed (Month, Day, Year) AUG 2 7 12-06052

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ennis Anderson		State - For State Registrar	of Maryland / De	epartment of Ce <i>rtificate</i> of a		d Mental Hy		No. 201	2 2727
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Las Dennis	William	Ander	son		Date of Death     Month     August 12,		3. Time of Death 1950 hrs
rouioui Examin		4a. Facility Name (if not institution, give	e street and number)			Location of Death	/ tagast 12,	4c. County of Death	'e
Funeral	4	Prince George's Hospital ( 5. Social Security Number 6. Se		rs. last birthday)	If Under 1 Yea		. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
Director		577-96-1835 <sub>1</sub> K	M 2_F	51 Yrs.	Months Day	s Hours Min.	02/21/	1961 Foreig	intry) D.C.
any	-	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Locatio					10d. Inside City Limits
<b>≜</b>	<u>اة</u>	DC none		Washing				g. Citizen of What Cour	1 X Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be potified at once.	흔	10e Street and Number 4268 East Cap	pitol Stree		10f. Zip Code 2 0 0			U.S.A.	
death with	Funeral	11. Marital Status 1 Never Married 2 X Married	1 Yes 2 X	If Ye	s, specify Cubar	spanic Origin? ( Sp n, Mexican, Puerto		14. Race - Ameri White, etc.	ack
rs after ural", o	ð.	3 Widowed 4 Divorced	If Yes, Give Year or Dates: hly highest grade completes	d) 16a. Decedent'	Yes 2 No s Usual Occupa	tion (Give kind of v		Specify: DI	
5-0036 led within 72 hours after Hygiene. I other than "natural", the Medical Examine.	Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+)		_	DO NOT use reti		Private	Industry
21215-0036 Juid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 228-f she ic event, the Medical Examiner must be notified at once	Be Con	17. Father's Name (First, Middle, Last) William Ander				18.Mother's Name Julia	(First, Middle, Ma Jackso		
	2	19a. Informant's Name/Relationship (T Sharon Robinso			Address (Stree	et and Number or F Capitol ngton,	Rural Route Numb	per, City or Town, State	Zip Code)
	-	20a. Method of Disposition  1 X Burial 2 Cremation 3	X Removal from State	COb. Place of Disposit crematory or othe Glenwood	ion (Name of cear or place)	metery,	Date / 22/12	20c. Location - City or Washing	
Baltimore, bernit. Pages 1 an Department of Hee (mportant: If ite		4 Donation 5 Other Specify 21. Signature of Funeral Sorvice Licer	CC053	30 22 Na	emetery ame and Address trey	y <u> </u>	al Home	Washing	20011 DC
Physician	$\dashv$	23a. Part I. Enter the disease, or comp	lications that caused the d	eath. Do not enter the	e mode of dying,	such as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		failure. List only one cause on ea Immediate Cause (Final disease a. or condition resulting in death)	Hypertensive Due to (or as a consequen	Atherosc	lerotic	Cardiova	scular l	)isease	Death
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and transit	edical Examiner	events resulting in death) Last d.							
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Box 6876( e death certificate the attending phy ed for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 4 Pregnant at time	2 Feta	al death 3 er (Specify)	Ectopic pregna	ancy		Day Year
BOX he death y the atture of for the atture of the atture	hysi	1 Yes 2 No 9 Unknown  Part II. Other significant conditions	9UIINIOWII			given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
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F Vitz Physicia ar this ce	일	examiner?  1 ✓ Yes 2 No  27. Manner of Death		2 ER/Outpatient		Other <sub>4</sub> Nursir	ng Home 5 F	Residence 6 Other	:
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Division of Vital Records, P.O, ra or Attending Physician: The law requires that the safter death.  11 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	be 28e. Place of Injury -	At home, farm, stree	t, factory, office	building, etc.	28f. Location (S or Town, St		ral Route Number, City
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physocompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical C	29a. Certifier 1 Certifying Physic	ian: To the best of my kno	wledge, death occurr tion and/or investigati	ed at the time, d on, in my opinio	late and place, and n, death occurred	due to the cause at the time, date a	e(s) and manner as stat and place, and due to th	ed. e cause(s)
	Me	29b. Signature and title of certifier	and manner stated.		29c. Licen			29d. Date signed (Mo	
5 1500		30. Name and address of person who	completed cause of death	(Item 23a)	0.0	.M.E.		August 13, 2012	
		Ling Li, MD Assistant N	ledical Examiner	900 W. Baltimor		Itimore, MD 2	1223		
St Regist	ate	31. Date filed (MANUG ay 2°1) 20	12 Registrar's Si	gnature pass	No.				

Jason	Linwood	Bidinger	

		1- For State Registrar		_	Cer	tificate o	f Death			Reg	ı. No.		
Physici Medical Exam		1. Decedent's Name (First			BIDI	NICE	7			Date of Death Month	Day Yea		3. Time of Death 2135 hrs
nedical Exam	mer	JASON L 4a. Facility Name (if not in				-10661		n, or Location of		August 10,	2012 4c. County o	f Death	2135 118
		Western Maryland Health System Cumberland									Allegany		
Funeral		5. Social Security Numbe	r 6. Sex	7	'. Age (In yrs. Ia	ast birthday)	If Under 1		_	B. Date of Birth	(MM/DD/YYYY)		
Director		212-88-44-	14 181	M 2 F	37	Yr		Days Hours	Min.	7/19	11975	Foreign Cou	ntry) MD
y		Usual Residence of Dece			Lag- Oit-	Town or Loca							404 L-54-03-13-35
ow any			County EDF0 R	20				ILLS					10d. Inside City Limits  1 Yes 2 No
Aaryland 28a-f show 1 at once.	ctor	10e. Street and Number	LDFOR			7 7 7 10	10f. Zip Co		1	1100	. Citizen of Wh	at Count	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.	Director		YSTON	Nu	ROAD			534			USM		.,,
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21215-0036 vuld be filed within 7. Mental Hygiene. marked other than		17. Father's Name (First,		DING	-E P						iden Surname)	111	
212 aid be Menta marke	o Be	19a. Informant's Name/Re	_		561	19b. Mailin	a Address (S				DIE er, City or Town	_	
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Pages		4 Donation 5 0	-	_ Keliloval IIoli	MA	DIEY	CEMET	ERY	8-15	5-12	BUFFA	LO M	11115 PA
Baltimore, permit. Pages 1 a Department of He Important: Wite		21. Signature of Funeral S		e / / / /	70	22. 1	Name and Add	ress of Facility	HARU	EY H.	ZEIGL	ER	FUNERAL
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876 tificat ng ph as the		IF FEMALE: 23b. Was decedent pregna past 12 months?	ant in the	1 Live birt	itcome of pregn h	_	tal death	3 Ectopic	pregnancy		23d. Date of d Month	delivery Da	y Year
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Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it.	Certific	3 Suicide 6 X	Could not be determined	(Specify)	of Injury - At ho		et, factory, offi	ce building, etc		or Town, Star	te)Marvla	rorRura I <b>nd</b>	I Route Number, City
Cospita 1 hours 1 unera	ဦ	4 Homicide 29a. Certifier 1 Certifi			Unknov		rod at the time	a data and nia		<u>ımberla</u>	nd , MD . s) and manner a		
To the How within 24 h To the Fur completely	Medical		al Examiner: 0	on the basis of	examination an						d place, and du		
7. W. T.	Me	29b. Signature and title of		nd manner sta	led.		29c. Lic	ense number		12	29d. Date signe	d (Monti	h, Day, Year)
		Carol	1460	Cla			0.	C.M.E.		].	August 11, 2	2012	
0		30. Name and address of											
Y		Carol H. Allan, M		~	I Examiner stræ's Signakur	Α .	altimore S	street, Baltii	more, Mi	21223			· · · · · · · · · · · · · · · · · · ·
Regist	ate	31. Date filed (Month, Day AUG 2 7 20	Year) De	una se	A. Ala	ale							

Please Type or Print in Black Indelible ink 8579479 All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :17a M Adib Bou-Saba Georges Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Plata ledica . Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Hours Country) Director 243-29-1123 1 X M 2 - F 64 11/20/1947 Lebanon 23a or 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director Waldorf Charles 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3435 Carnation Pl. Unit 20602 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.' Black White etc. 1 Never Married 2 Married ☐ Yes 2 X No þ 1 Yes 2 X No Specify: If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the Gulf Station Gas Station Manager Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Adib Georges Bou-Saba Matilda Georges Simaan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health mportant: If item 27 3435 Carnation <u>G. Bou-Saba/Spouse</u> Randa Unit Waldorf injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Ce 108/14/12 Waldorf, MD Qonation 5 Cother (Specify) St. Peters Ch. of Funeral Service Lice 22. Name and Address of Facility Raymond Funeral Svc., MO1517 La Plata, MD20646 Washington Ave., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Due to (or as a conseque ce of) disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi and Due to (or as a consequence of): resulting in death) Last Physician/Medical Physician: The law requires that the death certificate be Box 68760 the SB IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached f Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this y filled in by the funeral di After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 5  $\square$  Pending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours Medical within 24 hou To the Funer completely fil 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Bradstock Janet Marsh August 1819 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11 East Third Street Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Ohio **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Y May 3, 1 287-42-6074 63 Director 1949 Usual Residence of Decedent hal Hyglene. ed other then "netural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 U.S.A. 11 East Third Street within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Mantal Status 14. Race - American Indian, Black, White, etc. Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Completed Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College, (1-4 or 5+) enould be filed wi.
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vr traumatic ever\* Public School School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Leah Kunsman Merle C. Bradstock and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Bushong Road, Leola, PA 17540 Mrs. Linda B. MacDougall, sister permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other th 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemeter, cremator or other place) Landing Rock Cemetery Sept. 7, 2012 Kent Ohio 21. Signature of Puneral Service Licens 22, Name and Address of Facility Keeney and Basford PA Funeral Home M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximated Cause (Size) Approximate Interval Between Onset and Death Immediate Cause (Final DISEASE Physician/ ARTERY DRONARY disease or condition UNICHOUN Medical resulting in death) Due to (or as a consequence of): Examiner DIABETES MANY YEMPS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit HYPERTENSION YEAR MAN or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 bours after death.

To the Funeral Director: The this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian Physiclan/Medical YEAR PERLIPIDEMIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 Yo Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ANEMIA 1 Yes 2 No 3 Probably 4 Unknown DISEASE CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 RENAL 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Vatural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) row Kore JUIGUR, M 1)0060764 0 DV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DOHNSON DR/ OHANIC, MO) REDERICK BRANISLAV THOMAS 31. Date filed (Months Say, Year) State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20akb Per FH G931 9/04/2012 JH State of Maryland / Department of Health and Mental Hygiene amend #20b&c Per FH 6932 10/02/2012 Jh 1 - State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2.09 PM August 2012 Sheryl Lynn Brereton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Buenie It imore Washington Medical Center ANNE Hrunde Glen 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Jirthpiac Jountry) OW York **Funeral** Hours Min 1941 102-32-3413 70 Director 1 □ M 2 🛣 F Nov. New Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 ¥ Yes 2 □ No Maryland Anne Arundel Severn 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 1838 Dove Court 21144 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian other traumatic event, the Medical Examiner Black, White, etc. o ģ 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced 1 ☐ Yes 2X No Specify Specify: Black should be filed within 72 hours aft and Mental Hygiene. is marked other than "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th yrs. <u>Care Provider</u> State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kenneth L. Hollon Mamye E. Stubbs BREREton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is ... any injury or other trees. Erika L. Brereton (Daughter) 9025 A Thamesmeade Rd Laurel, Md. 20b Place of Disposition (Name of MDceNational) occupation 9/26/0212 20a. Method of Disposition 20c. Location - City or Town, State Laurel, MD 1 X Burial 2 Cremation 3 Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Arrapolis, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, 2\_Forest Dr. Annapolis, Larry 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph\_sician/ 500813 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEMON. Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of) physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE ISe 23c. If yes, outcome of pregnancy
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9 Unknown Por Month Day Pregnant at time of death the g Unknown s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law prior to completion of cause of death?

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ HERBERT BURGOYNE 6:38 PM2012 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death BOWLE 150W16 ENTER 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 🗆 F Months Days Hours Syracuse, New York 540-26-1621 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Director Prince George's Hyattsville 1 X Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a should be more and Mental Hygiene.
Its marked other than "natural", or items 23a 5006 56th Avenue 20781 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Government Cartographer Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Herbert Burgoyne Florence Mludred 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest E. Mendehall / Nephew 13203 Ithan Lane, Bowie, MD 20715 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 8/7/2012 Metropolitan Crematory Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) / Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine the burial-transit resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown be detached 9 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed ŽN No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident
Suicide 2 No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month

Maryland 21215-0036

Baltimore,

Records,

**Division of Vital** 

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 2012 0322 CHERYL DENISE BALLARD-JONES 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death PRINCE GEORGE'S COMMUNITY HOSPITAL PG **CHEVERLY** 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) 577-76-0645 56 1 □ M 2 🛛 F 06-17-1956 DC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State WASHINGTON 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20019 US 3734 D STREET SE, #101 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 Yes 2 No Black, White, etc 1 Never Married 2X Married BLACK 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL WORKER DC GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SARAH TRENE TOBIAS AUGUSTUS BALLARD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1648 TRINIDAD AVE, NE #4, WASH., DC 20002 JOSEPH JONES/ HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place)
LINCOLN MEMORIAL CEMET. 8-10-12 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State SUITLAND, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. of Funeral Service Lice 5538 MARLBORO PIKE, FORESTVILLE, MD 20747

Physician. Medical Examiner

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Division of Vital Records, P.O. Box 68760

Physician/

Medical

Examiner

**Funeral** 

**Director** 

28a-f show

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death

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Baltimore, Maryland 21215-0036

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Physician/Medical Examiner the þ Completed funeral director, Medical Certificate: To Be filled in by the

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica NE 1

> State Registrar

29b. Signature and title of ce

shock, for heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  Due to (or as a consequ	CALSIAC	Arryth	met.		Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					
Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1  Live Birth 2 Feta 4  Pregnant at time of a	al death 3 🔲 Ectopic i			23d. Date of de Month	livery Day Year	
Part II. Other significant conditions cor	ntributing to death but not res	sulting in the underlying	cause given in Part I.			the cause of death?	
				24a. Was an autopsy performed'	prior to death?	topsy findings available completion of cause of s	
25. Was case referred to medical			26. Place of Death (Che	eck only one)			
examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3 D	OA Other: 4 Nursing	Home 5 Residence	6 Other (Spec	cify)	
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	28a. Date of injury (Month, Day, Year)		8c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2 Medical Examin	cian: To the best of my know er: On the basis of examinatio	on and/or investigation, in	my opinion, death occurred	at the time, date and pla	ice, and due to the	cause(s) and manner stat	

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Cheverly UD

29d. Date signed (Month, Day, Year)

2012

DHMH 17 Rev 06-2011

no completed cause of death Item 23a) (Type, Prin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AIOUMATA 20:02PM BANGOURA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** TAKOMA ASHINGTON ADVENTIST MONTGOMERY 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 216-51-5558 Hours Min 38 Director 1 □ M 2 🕱 F 29 GUINEA Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director TAKOMA 1 X Yes 2 □ No MONTGOMER 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20912 GUINEA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) NURSE HEALTHCARE SER. nand Mental Hygien other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ BANGOURA MAMADOUBA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip t of Health a 11242 NABY SOUMAH Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or Department Important: It any injury or 10/12 FREDERICK MD. ADEN MUSLIM FUNERAL SER 21. Signature of Funeral Service Lice see Mo #1070 WOODBRIDGE 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Cequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a trar Due to (or as a of resulting in death) Last physician Physician/Medical that the death certificate be Box 68760 the as attending plant lor use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months Day Month Year Pregnant at time of death
Unknown the 9 Unknown P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires 1 Yes 2 Ho 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate 2 No 2 🗓 Yes To the Hospital or Attending Physician: 25. Was case referred to me Be 26. Place of Death (Check only one) examiner? Other: မ 1 Hipatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after used.

To the Funeral Director: After a second of the full of the further filled in by the further furth injury Natural 5 Pending work' 1 Tes 2 🗌 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowled edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29c. License 29d. Date signed (Month, Day, Year) 54 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7701 2091 a Registrar's Signat

State

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	nate of maryial		tificate of		na wentari		eg. No. 20	12 2728
Physici Medical Exami		Decedent's Name (First, Mid						2. Date of Dea	th	3. Time of Death
wedical Exam	mer	Amy Carol Ca  4a. Facility Name (if not institut		hor)	14	City Town	or Location of Dea	Month August 16	4c. County of D	1041 hrs
		2300 Blacks School		n Location of Dea	ILI I	Carroll	ream			
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs, Ia	st birthday)	If Under 1 Ye	ear If Under 24H	rs. 8. Date of Bir	th(MM/DD/YYYY) 9	. Birthplace (State or
Director		217-62-0279	1 M 2 XF	49	Yrs.	Months Da	ys Hours M			oreign Country) MD
ķ		Usual Residence of Decedent  10a. State 10b. Count		Ino City 1	Town or Locatio		<u> </u>			10d. Inside City Limits
_ &			roll		eytown					1 Yes 2 X No
Aaryland 28a-f show any 1 at once.	ctor	10e. Street and Number				10f. Zip Code			0g. Citizen of What	
death with the Maryland or items 23a or 28a-f sho must be notified at once,	ral Director	2300 Blacks So				2178			USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	Funera	11. Marital Status  1 Never Married 2 X	Married Armed Ford	dent Ever in U.S ces? 2 💢 No	If Yes	s, specify Cuba	an, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - A White, e	merican Indian, Black, tc.
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2 hour	ted	<ol> <li>Decedent's Education (Sp Elementary/Secondary (0-12</li> </ol>					ation (Give kind o e. DO NOT use re		16b. Kind of Busine	ess/Industry
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121 d be fi fental arked event,	Be	Sidney Saperst  19a. Informant's Name/Relation			Laoi sa su			e Rosenb		
MD 2 d 2 shoul lth and N n 27 is m	٩	Douglas Caltri		nd	2300 B	lacks S	ect and Number of Schoolhot	ise Road	nber, City or Town, S Taneyto	wn, MD 21787
E E E		20a. Method of Disposition		20b. Pl	ace of Dispositi		emetery,	Date	20c. Location - Cit	y or Town, State
MOFE Pages 1 tent of H int: If i		1 Burial 2 Crematic			ematory or other		n 8/2	21/2012	Hampstead	d, MD
Baltimore, permit. Pages I an Department of Hot Important: If ite injury or other tr		21. Signature of Funeral Service			22. Na	me and Addres	itesiity Fu	neral Hor	ne and Cha	apel, P.A.
	_	23a. Part I. Enter the disease, of	or complications that was	1 dteeb ed bes	41	2 Washi	ington Ro	oad, West	tminster,	MD 21157 Approximate Interval
Physician /Medical		failure. List only one caus	e on each line.			mode or dying	, saor as caralac	or respiratory arre	ot, anoth, or ricart	Between Onset and Death
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ed usit	Examiner	events resulting in death) Last		onsequence of):						
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath.  tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit.	Medical	UNPENDED	d AMENDED							
760, cate be physic the bur		IF FEMALE:		tcome of pregna	ancy				23d. Date of deli	very
ox 687 eath certific attending	ian	23b. Was decedent pregnant in past 12 months?	I LIVE DILL	h It at time of deat	_ =	death 3	Ectopic pregr	nancy	Month	Day Year
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P.O. BOX	by PI	Part II. Other significant cond	tions contributing to d	eath but not res	ulting in the und	lerlying cause	given in Part I.			e to the cause of death?
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Division of Vital Records, talor Attending Physician: The law requirers after death.  11 Director: After this certificate has been sided in by the fameral director, page 2 should be the fameral director, page 2 should be the fameral director.	Certification:		nding	ay,Year)		1	Yes 2 No			
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Div To the Hospital or within 24 hours afte To the Funeral Di completely filled in	Medical		Physiclan: To the best on aminer: On the basis of aminer state and manner state	examination and						
E 2 F 0	ž	29b. Signature and title of certifi				29c. Licens			29d. Date signed (	
		U-V L.				O.C.	M.E.		August 17, 20	12
FU	ſ	<ol> <li>Name and address of person</li> <li>Donna M. Vincenti, N</li> </ol>		,	,	/ Baltimore	Street Ralli	more MD 212	223	
St	ate			strar's Signature			Judet, Dalli			
Regist		31. Date filed (Month, Day, Year AUG 2	(2012 Dev	un B	back	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 27286 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mable Allie Cowatch 20, 2012 2:10 P M August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 214-46-2965 90 Director 1 □ M 2 🕏 F West Virginia 09/06/1921 Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Westernport 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Duckworth St. 21562 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ۾ 1 Never Married 2 Married Maryland 21215-0036 Specify: White If Yes, Give 1 ☐ Yes 2. No Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+ Housework Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claud Fraley Bessie Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Taylor/ daughter 202 Likens St, Westernport, Maryland 21562 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Potomac Mem. Gardens 08/24/2012 Keyser, West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ZHE (ME) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate carrie. Ent. I Industrying Cause (Disease or injury Due to (or as a consequence of) Exam The law requires that the death certificate be executed burlal-transl that initiated events resulting in death) Last Due to (or as a consequence of): ettending physician I for use as the burla Physiclan/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Pregnant at time of death signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔽 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy 1 ☐ Yes 2 ☐ No Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 💆 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 12690 Helle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 2. Registrar's Signature AUG 2 1 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:55 Medical 4a. Facility Name (if not institution, give street and number or Location of Death County of Death **Examiner** foote Washington George Terrace rince If Under 1 Year | If Under 24 H/s. | 8. Date of Birth Birthplace (State or Foreign Country) Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 64 Director Usual Residence of Decedent 3a or 28a-f show the notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director alitax 1 Yes 2 X No 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ns 23a r : must b Funeral 10 or items 12. Was Decedent Ever in U.S. Armed Forces?,
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No "natural". 3 ☐ Widowed 4 ☐ Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Wor Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Numbe Department of Health a Important: If item 27 is any injury or other traionce. aughter 20a. Method of Disposition 20b. Place of Disposition (Name of I ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License or complications that caused the death. Do not enter the mode of dying 23a. Part 1. Enter the disease shock, or heart failure. Li Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and attending physiciar Physician/Medical Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 9 Unknown Unknown page 2 should be detached Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examine 1 မ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurs occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 3m se of death (Item 23a) (Type, Print Registrar State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/  $^{\text{Day}}6$ 2012 August Keith Edwin Deaver 0605 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Days  $J_{\mathbf{u}}^{(Month,Day, Year)}$ 972 Hours Maryland Director 217-98-5352 40 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Ceci1 E1kton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2 Robin Hood Drive 21921 United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 9 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exan Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melton P. Deaver Judy Schneiders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy S. Deaver/Mother 2 Robin Hood Drive, Elkton, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 21. 4 Donation 5 Other (Specify) 2012 West Chester, PA R. A. Ferris & Co., Inc. 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ RENAL ACUTE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence sician and bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buna Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Minknown Completed 1 Tyes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 ☐ No 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 6 \( \subseteq \text{Other} \) Other (Specify) 1 Yes 1 SInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Fune completed fil 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D73684 AUGUST, 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOWSTREET ELKTON ND 21921 106

State Registrar 31. Date filed (Mor.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **Phyllis** Eileen Aug 11 Dorsey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Garrett Goodwill Mennonite Nursing Home Grantsville Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🗆 F Months Hours (Month, Day, Year Director 216-22-6881 Oct 18 MD or 28a-f show 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Grantsville MD Garrett 1 🗌 Yes 2 📮 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21536 USA 891 Dorsey Hotel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐XNo Specify: 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hilda Leah Squires John F. Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 and 2 s Health Joseph Dorsey Jr. Route 2, Box 544 WV 26753 Ridgeley son item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Donation 5 Other (Specify) 8/15/201 Restlawn Memorial Garden's MD LaVale 21. Signature of Euneral Service Lidensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Trief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, wheart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Unknown Records, P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No this certificate 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 2 No Hospital Other: ြုင 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending in 24 hours after deau...
The Funeral Director: Aft 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29b. Signature and title of certifier D0034231 State

DHMH 17 Rev 7/2009

Registrar

U.S.A. 14. Race - American Indian, Black, White, etc. White 16b. Kind of Business/Industry own home 18. Mother's Name (First, Middle, Maiden Surname) Pauline Ruth Welty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Taneytown, MD 21787 20c. Location - City or Town, State Uniontown, MD 22. Name and Address of Facility Hartzler Funeral Home, P.A. New Windsor, MD 21776 Approximate Interval Between Onset and Death 23d Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Pother (Specify) NPA11 EN HOS PIG 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

11:10 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

Carroll

Country)

Maryland

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

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Deborah Fedorkowice	State of Maryland / Department of Health and Mental Hygiene		2012	2720
1- For State	Certificate of Death	Dee Ne	2012	2123

Debolali i edol		1- For State Registrar	tate of Marylan		rtificate			illal ny	R	eg. No.	201	2 2729
Physic Medical Exam		Decedent's Name (First, Middle Deborah Fedori)	•						2. Date of Dea Month August 14		Year	3. Time of Death 1400 hrs
		4a. Facility Name (if not institution	on, give street and numb	oer)			Town, or Location	n of Death	/ tagaot 1	4c.	County of Death	
- Jack		1303 McKinley Street  5. Social Security Number		Ago /In ura	last birthday)	1	apolis der 1 Year I If Und		lo para de		nne Arundel	(2)
Funera Director		214-66-4781	1 M 2 X F	Age (III yrs.	59 Y	Mont		der 24Hrs. rs Min.	07/24/		DD/YYYY) 9. Bird Foreig Cou	npiace (State or n <sup>untry)</sup> Georgia
Any		Usual Residence of Decedent  10a. State 10b. County	-	10c. City	, Town or Loc	ation						10d. Inside City Limits
and f show	6	Maryland Anne	Arundel	Ann	apolis							1 Yes 2 No
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vith the s 23a o	eral D	1303 McKinley	Street 12. Was Decede	ent Ever in II	S 13 V	Vas Deced	401 ent of Hispanic Or	rigin? / Sn	acify Vas or No		US 14. Race - Americ	
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be fi	Be	John L. Fedork							ie Tucl			
MD 21 d 2 should lth and Me n 27 is man	ြင	19a. Informant's Name/Relations Joseph J. Fedor		hor	200		s (Street and Nu Channel					
		20a. Method of Disposition		20b.	Place of Dispo	sition (Na	me of cemetery,	Toau,	Date		ocation - City or	
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 X Cremation 4 Donation 5 Other S		State Ka.	crematory or o			8-17	7-2012	Edg	ewater,	Maryland
Baltimo permit. Pages Department o Important:		21. Sign to e of Fund ral Sonice			22.	Name and	Address of Facilit	ty Geo	orge P.	Kal	as Funer	al Home
Physician		23a Part I. Enter the disease, or	complications that caus	ed the death	Do not enter	973 S	olomons	Islar	nd Rd	Edg	ewater.	MD 21037 Approximate Interval
Medical		failure. List only one cause Immediate Cause (Final disease	on each line.						respiratory arre	031, 31101	sk, of fiear	Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cor			ascar	ar bisea	150				
	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence o	f):	<del></del>						
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iox 68760, eath certificate be executed attending physician and for use as the burial - transii	cian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outdine 1 Live birth	come of pregi		etal death	3 Ectopi	ic pregnan	су		Date of delivery Month Da	ay Year
OX 6 eath cer attend	100		4 Pregnant  Known 9 Unknown	at time of de	oth =	other (Spec	cify)					
O. B. at the de lby the	Phy.	Part II. Other significant conditi		ath but not re	esulting in the	underlying	cause given in Pa	art I.	23e. Did to	bacco u	se contribute to the	ne cause of death?
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of \ ing Phy After th uneral	n: To	27. Manner of Death	28a. Date of Ir (Month, Day		28b. Time of		28c. Injury at Work		28d. Describe h			340110
Sion Attendideath. cctor:	catio	1 X Natural 5 Pend 2 Accident Inves	ling stigation				1 Yes 2					
Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Wheneral Directarh.  The law regulates been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification	4 Homicide deter	d not be mined (Specify)	Injury - At ho	ome, farm, stre	et, factory	, office building, et	tc. 2	28f. Location (S or Town, St		d Number or Rura	al Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical		nysician: To the best of miner:On the basis of ex and manner stated	amination ar								
	ž	29b. Signature and title of certifie				290	C. License number				ate signed (Mont	h, Day, Year)
		30. Name and address of person	who completed sauce of	death /llon	23a)		O.C.M.E.			Augu	ıst 15, 2012	
			ssistant Medical Ex			altimore	Street, Baltin	nore, M	D 21223			
Si Regis		31. Date filed (Month, Day, Year)	32 Registr	rar's Signatu	* 1.	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 14 Per FH G930 8/29/2012 JH

State of Maryland / Department of Health and Mental Hygiene
Amend PI line c, 27,28a-terthicate of Beath 10/11/12 trt
Reg. 20 | 2 For State Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) ∩av Year **Physician** 25 2012 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SUITLAND
If Under 1 Year If Under 24 Hrs. 2607 FORT DRIVE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 85 yrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min 1 XM 2 ☐ F Yrs Director 146-20-9822 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD PG SUITLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 2607 FORT DRIVE US or Items 23a 20746 Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. WHITE within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎗 No Specify: þ neturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12TH MANAGER PRIVATE 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) GERTRUDE MARIE FITZGERALD WILLIAM OSWALD FRENCH SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) MAUDIE MAYS/ FRIEND 2607 FORT DRIVE, SUITLAND, MD 20746 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State RIVERDALE PARK 8-3-2012 4 □ Donation 5 □ Other (Specify) RIVERDALE, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service License 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Mant 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DYSPHAGIA Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed COMPLICATIONS OF HIP AND TIBIA FRACTURES Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical CERTIF IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?

1 9 es 2 No ours after death.

nerel Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Mesidence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manni 28b. Time of Injury Death 28c. Injury at Work? Certification: SUBJECT PEDESTRIAN STRUCK BY 5 Pending investigation 1 ☐ Yes 2 € No JUNE 1, 2012 9:21 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) IVERSON ST. NEAR 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide BRANCH AVE P.G. CNTY MD within 24 hours a
To the Funerel C
completely filled ROADWAY To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8-1-12 D0052756 450 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIAN TARROTT, M.D. 445 DEFENSE HWY, ANNAPOLIS, MD 21401 31. Date filed (Month, Day, Year) State

Registrar

32. Registrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral		5. Social Security Nu		er Road 6. Sex 1 <b>M</b> M 2 $\square$ F	7. Age (In yrs.	last birth	nday)	If Under							Harford  9. Birthplace (State or Foreign			
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To th Cong	_	29b. Signature and						29c.	License	number			29d. D	ate signed	(Month)	Day, Yea		
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81		AGATOR	JH.	who completed cause	WEC	3 1	ype, Pr	oint)	JA	RR	6 J	7500	10	2,1	Id	20	089	4
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 08 Month Physician/ Eloise M. Gist 19 2012 3:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2173 Sykesville Road Westminster Carroll If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Director 218-24-9655 1 M 2 X F 84 01/18/1928 MD 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 2173 Sykesville Road 21157 USA items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Armed Force Black White etc. þ 1 Never Married 2 Married "natural", or 2 X No 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8 manufacturing Westminster Shoe Fact and Mental Hygie is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Unknown Myers Blanche C. Berwager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Sipes/daughter item 27 1209 Stone Road, Westminster, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Zion UMC Cemetery 08/22/2012 Westminster, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Prints Funeral Home and Chapel, PA Mark le 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events death certificate be executed the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 Yes 2 No Yes 25. Was case referred to Division of Vital completely filled in by the funeral director, Be 26. Place of Death (Check only one) 1 Yes Other: ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural injury 5 Pending after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best-of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and ti 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

EXNESO

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Mendora

Washington

Red 2105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 8, Day 2012 Year Physician/ Goodson August 8:39 P M Т. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Mt. Airy Kline Hospice House If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Year) **Director** 579-38-4551 93 March 21, 1919 Washington, DC Usual Residence of Decedent Paga 1 and 2 should be fliad within 72 hours after death with the Maryland ment of Health and Mantal Hyglena.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Wedical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Potomac 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10555 Macarthur Blvd. 20854 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc à 1 Never Married 2 Married Specify:White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖺 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Wade Koontz Edith Brandt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Goodson/Son 10555 Macarthur Blvd., Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit, Paga 1 Department of Important: If it any injury or o 1 🖾 Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 11, Gate of Heaven Cemetery 4 Donation 5 Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause Final Onset and Death Physician/ Cardiomyopathy ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): g physician and as the burla-tragsit Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Breast Cancer 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

To the Hospital or Attanding Physician: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and rombiately filled in by the funeral director, page 2 should be dateched for use as the buriet transit. Box 68760 Records, P.O. **Division of Vital** 

		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
25. Was case referred to medical examiner?	26. Place of Death (Check on	nly one)		
1 ☐ Yes 2 🎦 No	Hospital:  1  Inpatient 2  ER/Outpatient 3 DOA Other: 4 Nursing Home	Hospice  5 Residence 6 Nother (Specify)		
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	n (Month, Day, Year) injury work?  M 1 ☐ Yes 2 ☐ No	Describe how injury occurred		
3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	1 28a Diaco of Injury - At home form etroot factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
20a Cartifier 1 X Cartifying Phy	sician: To the best of my knowledge, death occurred at the time, date and place, and	due to the caucale) and manner as stated		

29b. Signature ar MD

2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) D60417

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen Shah, MD 65-C Thomas Johnson Drive, Frederick, MD 21702

State Registrar

Medical

(Check

only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 7, .Day2012 Year 3:40 A M Linda Catherine Gaver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Boonesboro 6420 Old National Pike If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 217-56-2073 1 □ M 2 🕅 F 65 June 20, 1947 Maryland Usual Residence of Decedent filed within 72 nours are ital Hygiene.
ed other than "natural", or items 23a or 28a-f show
ed other than "natural", or items 23a or 28a-f show
event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Boonesboro 1 Yes 2 X No Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21713 6420 Old National Pike 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 X Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiens Important: If item 27 is marked other that any injury or other traumest-Hairdressing 12 Beautician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Frances Dorsey Joseph A. Gaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Woodholme Way, Elkton, MD 21928 Brother Joseph C. Gaver, Sr. August 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10, Rest haven 1 🕱 Burial 2 🗌 Cremation 3 🗌 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens Frederick, Maryland 21. Signer of Funer Service Licensee Resthaven Funeral Services, Skkot Cody P.A 9501 Catoctin Mountain Hwy. Frederick, MD 21701 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Part 1 Enter the d shock, or hear fail Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Examine Due to (or as a consequence of) tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical death certificate be Box 68760 SB IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Dav Pregnant at time of death the Unknown 9 Unknown P.O. I signed by the To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed 2 No 1 Yes Yes 2 V 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier

5 State only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cornack

Registrar DHMH 17 Rev 06-2011 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

			Plea	ase Type or Pri								_	jible.	
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	Physicia Medic	al .	EMMA  4a. Facility Name (if not institution	W. G	ALL	-10	<u> </u>	T-00 05	1 acction of De	Monte		4c. County	ŽÕ[2	0(20 M
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п	Director		223-52-7534	1 □ M 2 <b>½</b> F	90	Yrs.	MONUNS	Days	Hours	Jan.				
	thow at	៦	Usual Residence of Decedent  10a. State  10b. County	,		ity, Town or Location						10d. Inside City Limits		
	Maryla 28a-f etified	Director	MD	PG	s	uitl	and							1 🎗 Yes 2 🗆 No
	h the la or 2		10e. Street and Number				10f. Zij					. Citizen of		
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9	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Ma	Armed Forces?		l If	Yes, spe	cify Cubai	n, Mexican, Pu	erto Rican, etc.	)	Bla	ck, White,	
003	urs af tural", al Exa	ted	3 XWidowed 4 ☐ Divorce	lear of Dates.					Specify:			Specify	Bla	
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altimore, Maryland 21215-0036	ge 1 and 2 s it of Health if item 27 or other tra		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation		20b. Place	e of Disposetery, crem	sition (Na.	ne of	- 1	17°7°12	200	c. Location	- City or To	wn, State
Ε̈́Ξ	tment or tant: If ijury or		4 Donation 5 Other	Specify)		Hil	1 Ba	pt.	Church			Vict		
Bai	permit. Page . Department or Important: If any injury or once.		21. Signature of Funeral Service	Licensee	101	22	. Name a O 1 ∩	nd Addres	sof Facility H	odges	& E	dwar uitl	ds F	.H. MD.20746
			23a, Part 1. Enter the disease, of	or complications that caused	the death. D							<u> </u>	4110.7.	Approximate
	nysician/	3 3	hock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each line		PH	0 M	A					1.	Interval Between Onset and Beath
	Medical Examiner		resulting in death)	Due to (or as a										
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.89	certific inding use as	W/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Catania					23d. Da	ate of delive	ery
Box 68760	is that the death certificate be executed gened by the attending physician and be detached for use as the burial-transit	Physician/Medic	in the past 12 months?  1  Yes 2 No	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic Other (s					M	onth	Day Year
P.O.	at the d by th	, Phy	g ☐ Unknown  Part II. Other significant condit		ut not resulti	ng in the u	nderlying	cause giv	ven in Part I.	23e.	Did tobac	co use con	tribute to th	ne cause of death?
В, Р	ires th signe	Completed by								_	1 ☐ Yes	2 No	3 🗆 Prol	bably 4 🗆 Unknown
ord	w requires is been sig 2 should b	plete									Was an	24b.	Were auto	psy findings available mpletion of cause of
Rec	The law ate has page 2 s	Som									autopsy performed Yes 2		death?	4
tal	ician: certific rector,	Be	25. Was case referred to medica examiner?	Hospital:				Othe		heck only one)			A CIG	ATTER'S ILLIANS
Σ	r this eral dii	<u>ا</u>	1 Yes 2 No 27. Manner of Death	1 ☐ Inpati	ent 2 ER	b. Time of		28c. Injun	4 LJ Nursin ⁄at	g Home 5   28d, Desc		e 6 C Ott		TATER'S HUNE
on o	ath. r: Afte	icat		tigation	y, Year)	injury	М	work	? Yes 2 □ No					
Division of Vital Records,	or Atter frer de hirecto	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Hornicide deter	d not be mined 28e. Place of Inju- building, etc	ury - At home c. (Specify)	e, farm, stre	eet, facto	y, office			ion <i>(Stree</i> r Town, S		per or Rura	Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.		29a. Certifier 1 Certifyir	ng Physician: To the best of	mv knowlede	ge, death o	occurred :	at the time	e, date and pla	ce, and due to t	he cause	(s) and man	ner as stat	ed.
	n 24 h	Medical	(Check 2 Medical	Examiner: On the basis of eng Nurse Practitioner: To the	xamination ar	nd/or invest	tigation, ir	my opinio	on, death occur	ed at the time, o	late and p	lace, and du	ue to the ca	use(s) and manner stated.
_	with the contract of the contr	<	20b. Signature and title of certific		1	1.0	29	c. License	number	1/2 C	29d	Aate signe		
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	Sta Registr		31. Date filed (Month, Day, Year)	9 2012 32 Registr	ar's Signatur	be	ach	9			7			

			For	State	of Marylar	-	artment of H		Mental Hy	giene			
			State     Registrar			Cer	tificate of <i>E</i>	Death		Reg. No. 2	12	_27	298
	Physicia	n/	Decedent's Name (First, Mia	•					2. Date of De Month		Year		of Death
	Medic	al	Elizabeth Gra			s			Augus			1:45	5 A M
	Examin	er	4a. Facility Name (if not instituti				4b. City, Town, or Annapoli		:n	4c. County Anne		le1	
	Funeral		Anne Arunde1  5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		th	9. Birthp	olace (State	or Foreign
	Director		215-20-3066	1 □ M 2 🖾 F	87	Yrs.	Months Days	Hours Min.	1	c. 10, 1924 Rive			MD
	7 OM		Usual Residence of Decedent 10a, State 10b, Cour			to Tayla and a			Dec. 1	0, 1924		Od. Inside	
	ryland -f sh ied a	먕		e George's		ty, Town or Lo							es 2 🗆 No
	r 28a notif	Director	10e. Street and Number	- deorge			10f. Zip Code		1	10a, Citizen of	Nhat Cour		
	with the 23a cast be		4900 Rockvue	Pass			2071.	5		USA			
	tems er mu	Funeral	11. Marital Status		edent Ever in U.	.S. 13.\	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-		e - Americ		
98	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho ; the Medical Examiner must be notified at	þ	1 Never Married 2 😾 N	larried 1 Tes	2 X No		Yes 2 No		to Flican, etc.,	Specify	k, White, Whi		
21215-0036	ours a	Completed	3 Widowed 4 Divorce	ed Year or D dent's Education			lent's Usual Occup			16b. Kind of B	,,,,,		
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212	within giene. er tha		Elementary/Secondary (0-1: 12	college (	1-4 or 5+)	Vic	e Presid	ent		BB&T	Bank		
p	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle						me (First, Middle,	Maiden Surnam	e)		
yla	should be file n and Mental I 7 is marked o traumatic eve	۲	William Eugen					Ethel Y		-			
Maryland	2 shou Ith and 27 is m traum		19a. Informant's Name/Relatio		IIah an		ng Address (Street a Rockvue				State, Zip (	Code)	
	and thealt		James A. Hudg 20a. Method of Disposition	ins, Sr. /	20b.	Place of Dispo	sition (Name of		Date PID	20c. Location	- City or To	wn, State	
mo	Page 1 nent of ant: If it ury or c		1 ☐ Burial 2 🔀 Cremati 4 ☐ Donation 5 ☐ Othe		II State		natory or other place tan Crema		10/12	Alexand	ria.	Virgi	nia
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service		4		. Name and Addres			4739 B			
m	e a L		Claudette	Daschi			asch's Fu				ville	e, MD	20781
			23a. Part 1. Enter the disease shock, or heart failure. Li	or complications that st only one cause on e	caused the dea ach line.	th. De not ente	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approxim Interval B	etween
	Physician/		Immediate Cause (Final disease or condition	a	Co	nest	n he	ent to	, when		19	Onset and	Death
	Medical Examiner		resulting in death)	Due to	(or as a consec	quen of):	· cet	101	Lucas	2		W16	$\wedge$
	HA HA	Jer	Sequentially list conditions,	b. — Sue to	(or as a consc		Day	-	- , ,			)	
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687	ertifica ding p	ı wı	IF FEMALE:	23c If yes ou	utcome of pregn	ancv				024 D	to of dollar	017.4	
P.O. Box 687	eath certifica attending pl	cian	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live		taldeath 3 🛚	Ctopic pregnant Other (specify)	У			ite of deliv onth	Day	Year
Ö.	he de y the ached	hysi	9 Unknown	9 🗌 Unk									
P.0	requires that the der been signed by the s should be detached	Completed by Physician/M	Part II. Other significant cond	itions contributing to				ven in Part I.		tobacco use conf			
ds,	quires en sig ould b	ted	- C	311)	V n 4	eumo	3010		1	Yes 2 No	3 ∐ Pro	bably 4 L	Unknown
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ita	sician certifi rector	Be	25. Was case referred to die examiner?	Hospital:		1	Oth	ace of Death (Ch				,	
<u></u>	Phys r this eral di	은 :	27. Man of Death	28a. Date	Inpatient 2 = of injury	28b. Time o	28c. Injur	y at	Home 5 Res	how injury occur		<u></u>	
nc	ttending death. ctor: Afte y the fun	icat		estigation	nth, Day, Year)	injury	M 1 🗆	<br Yes 2 □ No					
Division of Vital Records,	l or Atte after de Directo	Certificate:		uld not be 28e. Place	e of Injury - At h	nome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	l Route Nui	mber,
ă	urs af rral Di			- 4							ner ne etni	and and	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Medical	(Check 2 Medic	ring Physician: To the al Examiner: On the ba ring Nurse Practitions	asis of examination	on and/or inves	tigation, in my opini	on, death occurred	d at the time, date	and place, and du	ie to the ca	use(s) and r	manner stated.
	To the vithin To the somple	Σ	only one) 3 L Certify 29b. Signature and title of cert		er. To the best of	Thy knowledge	29c. Licens		piace, and due to	29d. Date signe			
			> M.	- Dan	A		D	7766	,	8/2	100	17	
	10 2W		30. Name and address of pers	on who completed cau	use of death (Ite	m 23a) (Type, l	1	11 1	Λ		MA	7147	.1
			31. Date filed (Month, Day, Yea	Perro 4	Registrar's Sign	atu <b>4</b>	+care	Hyhr	y Hr	W-(WH)	111	JUL	1
	Sta Registr		AUG 1	0 2012	regional s olyn	p. 19	aver						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#9perINF, G931, 9/2/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 | 2 27299 State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 7, Tna Melvina Johnson 2012 ΡМ 7:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring 611 Mississippi Avenue 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Missouri 214-18-8138 **Director** 1 M 2 X F 94 Yrs. Aug. 25, 1917 <del>Michigan</del> Usual Residence of Decedent i and 2 should be filad within 72 hours aftar death with the Maryland f Health and Mantal Hygiena. Item 27 is markad othar than "nature!", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits ad other than "naturei", or items 23a or 28a-f sho avant, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2X No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 USA 611 Mississippi Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Completed by Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 David Rhodes Ertle Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 181 Stone Quarry Road, Cooperstown, NY 13326 Beverly J. Limar/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Aug. 8, 20c. Location - City or Town, State permit, Page 1 a Departmant of I importent: If Ite any Injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Metropolitan Crematory 2012 Alexandria, VA any in 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring,MD 20901 1 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Tha law raquires that the death cartificate ba executed burlahtra resulting in death) Last Due to (or as a consequence of): attending physician for usa as the burla Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live Birth 2 Live 4 Pregnant at time of death in the past 12 months? 5 Other (specify) Month Day 1 ☐ Yes 2 ☑ No 9 ☐ Unknown ate has bean signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Deep Venous Thrombosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 🗚 N To the Hospital or Attending Physicien: The within 24 hours after death.

To the Funarel Director: After this certificate it completely filled in by the funeral director, page 1 🗆 Yes 2 🗀 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🖾 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{X} \) Residence \( 6 \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide м Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) lkinsa D45285 2012 8 Ina 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkinson J. Ninala, MD 344 University Blvd. West, Silver Spring, MD 20901 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

AUG 1 0 2012

32. Registrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 27301 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 234 AM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Medstar Montgomery Medical Center 01ney Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 62 **Director** 216-17-6528 1**X** M 2 □ F Aug. 2, 1950 Ghana Usual Residence of Decede ms 23a or 28a-f show must be notified at 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20905 16601 Sea Island Court USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner 0 þ 1 Never Married 2 Married Specify Multi-Racial Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Physician Medical Be filed \ 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked any injury over any 18. Mother's Name (First, Middle, Maiden Surname) ပ Brendan William Augustus Tristram Knight Felicia Agnes Addison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mathilde Rosamude Knight/Wife 16601 Sea Island Court, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Lice Francis Agdress Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Inter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. 23a. Part 1. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): , Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and debt be detached for use as the burial-trail that initiated events resulting in death) Last Due to (or as a consequence of Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2. No Hospita Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1-Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 00607 2012

Registrar

Box 68760

P.O.

Division of Vital Records.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MISSA

10

18101 Prince Philip Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2<sup>Day</sup> August 2012 6:30 A M Medical Landis 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick North Hampton Manor Nursing Home Frederick If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Social Security Number 218–96–2830 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Director 46 Silver Spring 1-29-1966 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 200 East 16th Street 21701 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Stephen Landis Janet Magdilene Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a : If item 27 is Amber Bowie ( Daughter 6262 N. Steamboat Way New Market, MD 21774 Baltimore, 20a. Method of Disposition

1 Disposition 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, 4 Donation 5 Other (Spe Fort Lincoln Cemetery 8/8/2012 Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home Signature of Funeral Se Ce Licen Kuhan Brentwood, MD 20722 3401 Bladensburg Road none 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending absorbing the control of the control of the standing absorbing the control of Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 Å No ģ Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ þe Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 performed' Yes 2 XNo the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital မ 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury after death Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1 🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 8/6/2012 D 47951 154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sibte A Kazmi, MD 81/4 Toll House Ave Frederick, MD 21701

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d per DVR G930 8/27/12dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2012 09 PM August 7:45 Medical <u>Betty</u> Morella Lynch 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Waldorf Genesis Waldorf Center Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/06/1930 Funeral 9. Birthplace (State or Foreign Days 1 □ M 2 😾 F Months Hours Country) 82 Director Yrs 577-36-6960 Wash. Usual Residence of Decedent 28a-f show 10a. State 10b County notified at 10c. City, Town or Location Director 10d. Inside City Limits Brandywine 1 ☐ Yes 2 🛣 No MD Prince Georges 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 20613 United States 14512 Brandywine Heights Rd. 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within College (1-4 or 5+) Bank of Brandywine Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $2\,0\,6\,1\,3$ Ronald L. Lynch, Sr./Spouse14512 Brandywine Heights Rd., Brandywine, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory 08/14/12 Alexandria, VA 21. Signature of Funeral Service 22. Name and Address of Facility Raymond Funeral Svc., 5635 Washington Ave., La Plata, MD 20646 M01517 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or linjury signed by the attending physician and defacted for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnam
Unknown 5 Other (specify) Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔊 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performe death? 2 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖪 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation upleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

29

cause of death (Item 23a) (Type, Print

20%

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. d #4aPer Phy &10b per FH G931 9/21/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 2012 Meredith August 12 7:15A M Pansy Α. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Street Whiteford Harford 3970 Bay Road Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 216-30-8829 **Director** 1 □ M 2**X**X 79 West VA 1/15/1933 show Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Harford Street Whiteford 1 Yes X No 10e. Street and Number 10g. Citizen of What Country? Funeral 21154 21160 3970 Bay Road USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. λq 1 Never Married 2X Married 1 Yes 2 XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXo Specify: "natural", Completed 3 Widowed 4 Divorced Specify hite Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the own home <u>home maker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ James A. Sampson Virginia P. Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Meredith-husband 3970 Bay Rd.,Street,MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place) 1 ☐ Burial XX Cremation 3 ☐ Removal from State Evans Eagle Crematory 8/14/12 Leola, PA 4 Donation 5 Other (Specify) . Signature of Juneral Service Lic 22. Name and Address of Facility C Moke Harkins F.H.Inc., Delta, PA 17314 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death OVARIAN Physician/ disease or condition Y 12 ARD Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown 2 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. Completed 1 Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 AVO Other: 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) eral Director: After this filled in by the funeral di Certificate: 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 3 Suicide 5 Pending injury 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the P only one) 29b. Signature and title of c D002841) PHTSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21014 PHELIPHILATPUNIN SIOUPPIER CHIZSAPTAKI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last.) 2. Date of Death Physician/ Day 2012 Year Month Alda Sue Martin 17 Aug. 5:24  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 231-22-8487 1 M 2 XF 86 WV Jan 20, 1926 or 28e-f show 10b. County 10c. City, Town or Location 10a. State the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23e 21120 902 Walker Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. "natural", or <u>چ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health end Mentel Hygiene. Importent: If item 27 is marked other than " eny injury or other treumettc event, <u>the Me</u>e <u>once.</u> Airplane Elementary/Secondary (0-12) College (1-4 or 5+) Exec. Assistant Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Ruth Mary Zeigler George Amos Martin Page 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Martin/Nephew 902 Walker Rd. Parkton, MD 21120 Date 22, 20a. Method of Disposition 20b. Place of Disposition (Name of National Memorial Park 1 X Burial 2 Cremation 3X Removal from State 4 Donation 5 Other (Specify) Falls Church, VA 22. Name and Address of Facility JJ Hartenstein Mortuary, ture of Funeral Service Los 24 N. Second St. New Freedom, PA 17349 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final physician/ STA 6E disease or condition . Medical resulting in death) Due to (or as a consequence of) ∠xaminer Sequentially list conditions, Examine if any, leading to immediate cause Filter Indenying Cause (Disease or injury that initiated events Due to (or as a consequence of) buriel-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical be detached for use es the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ↑ To the Hospital or Attending Privitin 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and titl 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) 31 Date filed (Month State Registrar

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Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	if Und		f Under 24Hrs	_	,	9. Birthplace (State or Foreign
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10+1	-	30. Name and address of person	who completed caus	e of death (Item	1 23a)		O.O.IVI.E			, lugust 4, 20	
		Ana Rubio M.D., Ph. I	D. Assistant N			) W. Ba	ıltimore St	treet, Baltir	more, MD 21	223	
St Regis	ate trar	31. Date filed (Month, Day, Year) AUG 1 0 2	)12 Pener	gistrar's Signati	par	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 27308
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

	1- For State Certificate of Death Reg. No.										
Physicia Medical Exami	ner	1. Decedent's Name (First, Midd Serkalem Be	rhanu Meng	istu					17, 2012		3. Time of Death 0852 hrs
.)		4a. Facility Name (if not institution Holy Cross Hospital	on, give street and number)		4	b. City, Town, o Silver Spri		of Death		County of De lontgomer	
Funeral Director		5. Social Security Number 256-93-0708		(In yrs. las	st birthday) Yrs.	If Under 1 Ye			12/19		Birthplace (State or reign Country) Ethiopi
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'	-	30. Name and address of person	who completed cause of dea	ath (Item 23	3a)	0.0	.171		Augu	350 13, 20	-
		Donna M. Vincenti, MI			ner 900 V		e Street, I	Baltimore, MD	21223		J.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 27309 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:31 P. M AUOK Physician/ 2012 Wallace M. Maddox, Medical Facility Name (if not institution, give street and number) ounty of Death **Examiner** If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral Director** 217-30-0644 1 🛛 M 2 🗆 F Maryland July 16, 1935 77 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Charles LaPlata Maryland 10f. Zip Code 10g. Citizen of What Country? ō pe ms 23a ( must be Funeral U.S.A. 20646 6570 Cardinal Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces' 1 X Yes 2 If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 1953-56 Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) alth and Mental Hygiene.

27 is marked other than it traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) <u> Master Electrician</u> U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rueben A. Maddox Carrie Skinner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6570 Cardinal Dr., LaPlata, Md. 20646 Wife Shirley Maddox Baltimore, 20a. Method of Disposition

1 Disposition 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 17ate 2012 20c. Location - City or Town, State Important: I any injury or Waldorf, Maryland 4 Donation 5 Other (Specify) Trinity Memorial Gardens 21. Signature of Funeral Service Lic williams Funeral Home 4270 Hawthorne Rd., I e, P.A. Indian Head, Md. M00668 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the Interval Between Onset and Death shock, or heart ilure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) month Medical **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events Due to (pr as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 2 No Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending ours after death.

leral Director: Af

filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) To the Hospital o within 24 hours aff To the Funeral Di Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 2012 MID 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 2/06/ GEN BURNIE, MD PAUSMD6934 SUITEB AVIATION 31. Date filed (Month, Day, Year) State AUG 0 9 2012 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ Bobby Brent McClure August 3 3:50 a.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary Hospital St. Mary Leonardtown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Days Hours Min 1 **X** M 2 □ F Director 214-72-3573 56 May 15, 1956 West Virginia Usual Residence of Decedent 28a-f show 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland 1 Yes 2 X No St. Mary Tall Timbers 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? pe 23a Funeral death with 17838 4th Street must l 20690 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 01 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 Communication Specialist U.S. Government other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o Ford Cresent McClure Mable Dobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 s ment of Health item 27 Joe T. McClure Executor 200 Edelen Station Place, #304, LaPlata, Md. 20646 20b. Place of Disposition (Name of cemetery, crematory or other place Aug. 8, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Waldorf, Maryland 4 Donation 5 Other (Specify) Trinity Memorial Gardens Signature of Fundral Service Lic 22. Name and Address of Facility
Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Mo 20640 23a. Part 1. Effect be disease, or complications that caused shock, or heart failure. List only one cause on each line disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Dymany Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Conquetive ician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical c mon u the Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No for Day Pregnant at time of death Unknown 9 Unknown Records, P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by anemira 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Yes 2 No 2 No 1 Yes Division of Vital 25. Was case referred to medical Hospital or Attending Physician: 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending within 24 hours after death. To the Funeral Director. A completely filled in by the f 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) Do 60473

Registrar
DHMH 17 Rev 06-2011

State

25500 Point Lookout Rd., Leonardtown, Md. 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mehrdad Akhlaghi, M.D.

			1 - For State Registrar	te of Maryland /		nent of He cate of D			gien <b>e U</b> Reg. No.	12	2/3/1
	Dhusisi		1. Decedent's Name (First, Middle, Last)			-		2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Joyce	М.		Mars		8	6	12	4:16 p M
	Examin	er	4a. Facility Name (If not institution, give street a	Ct Apt 20	8	Walda				arks	
Г	Funeral		5. Social Security Number / 6. Sex 1 M 28	7. Age (In yrs. last i		Inder 1 Year oths Days	Hours Min.	8. Date of Birt (Month, Da) 10-30-	y, Year)	Cour	
	Director		Usual Residence of Decedent	73				10-30-	. 30	Mar	yland
	nyland how		10a. State 10b. County	10c. City, To	own or Location	1				1	0d. Inside City Limits
	e Ma 3a-f e	ctol	Maryland Charles	Wal	dorf						¥EYes 2 No
	with th	Directo	10e. Street and Number		10	f. Zip Code			10g. Citizen of	What Cour	ntry?
	eath v	eral	11060 Weymouth Ct.  11. Marital Status 12. Wa	Apt. 208 s Decedent Ever in U.S.	13 Was f	2060	panic Origin? (Spe	ecify Yes or No	USZ 14. Ra	ce - Americ	an Indian.
	fter d	Funeral	Arm  1 Never Married 2 Married 1 □	ed Forces? Yes 2 <b>∏</b> No	If Yes	, specify Cuban	, Mexican, Puerto	Rican, etc.)	Bta	ck, White,	etc.
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Maryland		To Be	James	в.	Marsha	11 .	Janie		Ε.		Brown
ar	2 should and Men and Men Is marka		19a. Informant's Name/Relationship (Type, Prin	nt) 1	9b. Mailing Ad	dress (Street ar	nd Number or Rura	al Route Numbe	r, City or Town	, State, Zip	Code)
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Baltimore,	Pages 1 and the of Her out: If item or othe or othe		20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Remova	from State ceme	of Disposition etery, crematory	or other place	)	Date	20c. Location		
	it. Pa irtmen irtent: njury		'4 □Donation 3 □Other (Specify)  21. Signature of Fyneral Service Ucenses	St.	Peters	Cem.	8-14	-12	Waldor	rf <b>,</b> Ma	ryland
n T	parmit. Pages: Department of I Importent: If ite eny injury or of		Therese Ki	Kney	Adam	s Fune	eral Ho			co	Md 20608
		3	23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. De on each line.	o not enter the	mode of dying	, such as cardiac o	or respiratory a	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hypen	lensu	m		<u>.</u>			
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	ue to (or as a consequenc	ce of):			-			
	rcuted nd transit	Examiner	that initiated events c								
Ö,	cate be executed physician and the burial-transit		resulting in death) Last	ue to (or as a consequenc	ce of):						
98/60	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dical	d								
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	w requires that been signed k should be deta	by F	Part II. Other significant conditions contributing	g to death but not resulting	g in the underly	ring cause give	n in Part I.				ne cause of death?
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Division of	g Phy ler thi	-			b. Time of Injury	28c. Injury Work		28d. Describe			
000	endin eath. or: Af	catlo	2 Accident investigation		N		es 2 No				
Ë E	or Att	Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, building, etc. (Specify)	, farm, street, fa	actory, office		28f. Location (: City or To	Street and Num vn, State)	iber or Rura	al Route Number,
_	spital ours a nerel (		29a. Certifier 1 Certifying Physician:	To the best of my knowled	dge, death occi	urred at the time	e, date and place.	and due to the	cause(s) and m	nanner as s	tated.
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Examiner: Or	the basis of examination d manner stated.	and/or investig	ation, in my op	inion, death occur	red at the time,	date and place	, and due to	o the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	1/-1 100		29c. License	number		29d. Daté sign	ed (Month,	Day, Year)
•	<u></u>		I purile fee	May land		D21	031		8/ /	112	
	00		30. Name and address of person who complete	d cause of death (Item 23.	a) (Type, Print)	In Ida	MO 21	Vico i			
	Sta	to	31. Date filed (Month, Day, Year)	nta Switz 32. Registrar's Signature		vicion t	IND of	مل ما			
	Registr		31. Date filed (Month, Day, Year) AUG 0 9 2012	Beneva 1	A. Sa	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert Harmon Myers, Sr. 2012 9:00 PM Medical August 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26615 Tin Top School Road Mary's Mechanicsville St. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Social Security Number Age (In yrs. last birthday) Months Hours Min. **Director** 579-56-0852 1 👿 M 2 🗆 F 68 Yrs. 09/13/1943 Usual Residence of Deced Washington, DC show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 28a-f 1 ☐ Yes 2 🛣 No MD St. Mary's Mechanicsville ò 10e. Street and Numbe 10g. Citizen of What Country? Funeral 23a 26615 Tin Top School Road death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White "natural" Completed 3 Widowed 4 X Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) 10College (1-4 or 5+) Painter Painter's Trade Union Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ္ Page 1 and 2 should be Harry Amos Myers, Myrtle Virginia\_Bruffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Robert Harmon Myers, Jr. 26615 Tin Top School Road, Mechanicsville, MD 20659 Son other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ **A**ther (Specify) Maryland Veteran Cem. 08/14/2012 | Cheltenham, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Signature of Funera Service Licenses ¶M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ench line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate

Cause (Disease or injury Due to (or as a consequence of): ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ģ Pregnant at time of death Month Day Year the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did topacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autops nerforr certificate 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNO Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Nesidence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After (Month, Day, Year) Natural 5  $\square$  Pending work death. 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after Hospital within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 횬 29b. Signature and title o 00

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State Registrar

DHMH 17 Rev 06-2011

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o completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year M Mary Christine Medley Medical August 2012 1323 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital <u>Leonardtown</u> Mary's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min (Month, Day, Director 220 16 8410 87 18. 1925 MD Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD St. Mary's Mechanicsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? and Mental Hygiene. Is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be r Funeral 26295 Loveville Road 20659 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: Black Completed 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12th Retail Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Thomas Mary Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Christine L. Kennedy/dtr 26280 Loveville Rd Mechanicsville, MD20659 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Joseph's Cem. St 8-11-12 Morganza, MD 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service Licenses 10N 38576 Brett Way Mechanicsville, MD20659 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician CACO-AC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner POXIA Sequentially list conditions, Examine cause. Enter Underlying sician and burial-transit Sta Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be the Box 687 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 L Yes 2 L 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 2 No 1 Tes Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No ၉ 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1X Natural 5 Pending Accident 24 hours after death. Funeral Director: A Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F 3 [ only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0060177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) " LEUPEN 524 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

Registrar

AUG 0 8 2012

Messey

12-06065

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 27314 Lois Jean MacDonald State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day August 13, 2012 Lois Jean MacDonald Medical Examiner 1340 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Route 36 and Vale Summit Road Allegany 5. Social Security Number 8, Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Days Director 217-30-2167 Months Hours 80 12/25/1931 1 M 2 X F Country) Usual Residence of Decedent iny 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Allegany Westernport 1 Yes 2 XNo rmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland pearment of Health and Mental Hygient portant; If item 72 is marked other than "natural", or items 23a or 28a-f sho jury or other traumatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22111 Horserock Road 21562 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White, etc. 2 X No Yes white 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ě 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker 21215-0036 12 Housework 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Dewey Kyle Be Ethel Michael 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott MacDonald/ son HC 71, Box 730, Augusta, WV 26704 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place)
Cumberland Crematory 08/16/2012 Cumberland Maryland 4 Donation 5 Other Specify: 22. Name end Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses n agne 111 Church St, Westernport, Maryland 21562 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of); cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical ttending physician a UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death Day Year detached for use as past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown of Vital Records, P.O. icate has been signed by page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 this 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury After 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? Aug 13, 2012 Passenger in vehicular collision 1 Natural 1335 hrs Division 1 Yes 2 ✓ No Pending the Certificati 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Route 36 and Vale Summit Road, Frostburg, MD within 24 hours a determined (Specify) Major Road / Highway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. S 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 14, 2012 30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State

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Registra

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	Dhamisis	,	Decedent's Name (First, Middle, Last)		imoato or E	- Catri	2. Date of Death		3. Time of Death
٠,	Physicia Medic	al	Marlene M. McVeagh				August	06 2	012 4:41 PM
	Examin	er	4a. Facility Name (if not institution, give street and number)  Meritus Medical Center		4b. City, Town, or Hagers	Location of Death		4c. County of I	
	Funeral		5. Social Security Number 6, Sex 7. Age	e (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	9	ashington Birthplace (State or Foreign
	Director		219-30-5570 1 ☐ M 2 🏋 F	76 Yrs.	Wionins Days	Hours Min.	(Month, Day, Yes		Country) Maryland
	land show dat	tor	10a. State 10b. County	10c. City, Town or Loc	cation		0000000	1,00	10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland antal Hygiene. Ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Funeral	17710         Red Oak Drive           11. Marital Status         12. Was Decedent E	ver in U.S. 13. V	Vas Decedent of His	21740 spanic Origin? (Spe	cify Yes or No-	USA 14. Race - A	American Indian,
36	after d	by	Armed Forces?  1 ☐ Never Married 2 🔀 Married  1 ☐ Yes 2 ☐  If Yes, Give	No	f Yes, specify Cubar  ☐ Yes 2 💢 No		Rican, etc.)	Black, V Specify:	White, etc.
00	nours a	etec	3 ☐ Widowed 4 ☐ Divorced Year or Dates.		lent's Usual Occupa		161	b. Kind of Busin	White
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land	be file lental l rked o ic eve	To	William Kowalski				eline Gard	,	
Maryland	should be file h and Mental I 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	nd Number or Rura	l Route Number, Cit	y or Town, State	e, Zip Code)
e, S	and 2 s Health tem 27		Hugh McVeagh / Husband 20a. Method of Disposition				lagerstown		
nor	- # ± 5		1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State	20b. Place of Dispose cemetery, crem	natory or other place	9)			y or Town, State
Baltimore,	permit. Page Department of Important: If any injury of once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee		. Name and Addres		Stauffer		vn, Maryland
Ö	an Jee		1 Jourtrey Stauf	le				rederic	k, MD 21702
			23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line.			g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	Medical	n i	disease or condition	STAGE consequence of):	COPD				Onset and Death
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	ecuter and Il-trans	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a resulting in death) Last	consequence of):					
09	ate be executed physician and the burial-transit	dical	d						
6876	tificate ng phy e as th	Med	IF FEMALE:						
Box 6	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	by Physician/Me	23b. Was decedent pregnant in the past 12 mooths?	2 Fetal death 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of	f delivery Day Year
Ö.	he dea y the a	hysic	1 Yes 2 No 4 Pregnant at 9 Unknown	time of death 5 L	Other (specify)			1	Day You.
O.	s that t gned b	by P	Part II. Other significant conditions contributing to death but	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc	co use contribut	te to the cause of death?
rds,	een siç	eted					1 Yes		Probably 4 Unknown
Records,	has b	Completed					24a. Was an autopsy performed	prior	e autopsy findings available r to completion of cause of rh?
ř E	an: The la tificate ha tor, page		25. Was case referred to medical		26. Pla	ice of Death (Check	1 🗌 Yes 2		Yes 2 No
Vita	hysician: nis certific il director,	To B		nt 2 🗆 ER/Outpatien	Otho	r:	me 5 Residence	e 6 🗌 Other (S	pecify)
Division of	tending Ph leath. or: After th the funeral		27. Manne of Death  1 ☑ Natural 5 ☐ Pending  28a. Date of injur (Month, Day)		28c. Injury work?	?	8d. Describe how in	njury occurred	
Sion	al or Attend s after death I Director: A d in by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	ry - At home, farm, stre		Yes 2 □ No	28f. Location (Street	and Number or	Rural Route Number.
DΙΣ	pital or Att		building, etc				City or Town, St		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier 1 Certifying Physician: To the best of a (Check 2 Medical Examiner: On the basis of ex	amination and/or investi	igation, in my opinior	n, death occurred at	the time, date and pl	ace, and due to	the cause(s) and manner stated.
	To the Hos within 24 hd To the Fun completely	ŭ	only one) 3 $\square$ Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	best of my knowledge,	death occurred at the	e time, date and pla	ce, and due to the ca	use(s) and mann	er as stated.
	-> H-O		Frull Dreesell)		400		A	16U5T	7,2012
	4		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, P	ulm 4)	US Me.	0'61		Hogerstown
	Stat	e .	31. Date filed (Month, Day, Year)  32. Pegistra	r's Signature		US MP	X1(0)	th 101	c, MO
	Registra		AUG 10 2017	a p. A	arke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward John McCann 2012 1:15 A M August Medical 4a. Facility Name (if not institution, give street and number)
Shady Grove Adventist Hospital Examiner 4b. City, Town, or Location of Death ROCKVIILE of Death Montgomery **Funeral** 5. Social Security Number 103–03–3964 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min Director 1 **X**M 2 □ F 94 Yrs Oct. 6, 1917 New York 28a-f show with the Maryland 10b. Count 10c. City, Town or Location Funeral Director 10d. Inside City Limits Maryland Montgomery Gaithersburg 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 301 Russell Avenue, #S249 23a 20877 U.S.A. items 2 11. Marital Status 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. Completed 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced White Year or Dates. WW II Specify 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) aith and Mental Hygiene.
27 is marked other than "r traumatic event, the Med College (1-4 or 5+) Elementary/Secondary (0-12) Civil Service U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward A. McCann Mary FitzSimmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 85742 Mary McCann Flynn/daughter Health em 27 3544 W. Skyridge Loop Tucson, Arizona 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1
Department of
Important: If it
any injury or o Date 20c. Location - City or Town, State 1 Burial **XX**Cremation 3 Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 8/9/2012 Glen Burnie, Maryland rui ral Si ice licensee 21. Signitu 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician. Aspiration Aspiration of: Onset and Death Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsv performed? Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ည 2 1 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending Investigation
6 
Could not be Accident 1 Yes 2 No Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 169148 5x) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) o 110 Molecular

State Registrar

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12-06101

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Richard Ostan	State of Maryland / Department of Health and Mental Hygiene

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Stephen Richard	1 F	I- For State Registrar	State of M	aryland /		rtment of tificate of		and	Mental I	R	eg. No.	2 2731
Physiciar Medical Examin	 er	1. Decedent's Name (First, Middle,Last)  Stephen Richard Ostan  2. Date of Deat Month August 14			Day Year 1, 2012	3. Time of Death 1526 hrs						
		4a. Facility Name (if not inst Atlantic General H	, 0	and number)			4b. City, Town Berlin	n, or Lo	ocation of Dea	th	4c. County of Deat Worcester	h
Funeral Director		5. Social Security Number	6. Sex	_		st birthday)		Year Days	If Under 24H Hours M	in.	rth(MM/DD/YYYY) 9. Bi	orthplace (State or 9n Pennsylvania
J. 100.01	+	209-58-9053 Usual Residence of Decede	1 X M 2	F <u>4</u>	9	Yrs				01/30	/1963	ountry)
w any		10a. State 10b. Cou	_	1		Town or Locat		<del></del>				10d. Inside City Limits 1 Yes 2 No
uyland		Pennsylvania  10e. Street and Number	Delaware		M	arcus I	look 10f. Zip Co	de		1	Og. Citizen of What Cou	11
th the Maryland 23a or 28a-f sho notified at once		37 West 3rd	Street				190	61			United S	tates
th with		11. Marital Status  1 Never Married 2	12. W	as Decedent E med Forces?						Specify Yes or No to Rican, etc.)		rican Indian, Black,
			Divorced If Yes, C	Sive Yeer	No No	1	Yes 2X	No	specify:		specify: Wh	ite
hours a	60 pg	15. Decedent's Education	Specify only highe	est grade comp		16a. Deceder during m			n (Give kind o		16b. Kind of Business,	Industry
D36 thin 72 ne. than	Completed	Elementary/Secondary (0	12) Co	lege (1-4 or 5+	)	Ste	vedore	9			Shippin	g
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than e event, the Medica		17. Father's Name (First, Mi		· ·				18		ne (First, Middle, I	Maiden Surname)	
2121 Mental Mental market	8 0 	James E. Ost		nt )		19b. Mailing	Address (S	Street a		s M. Mat	thews nber, City or Town, State	e, Zip Code)
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Ore,	- 1	20a, Method of Disposition 1 Burial 2 X Crem	ition 3 Rem	oval from State	CI	lace of Dispos rematory or oth	ner place)		Au	gust 21,		
Baltimore, permit. Pages I an Department of Healmportant: If ites in jury or other tr		4 Donation 5 Othe 21. Signature of Funeral Ser	Specify:	)	F	agano 22. N	Cremat	ory ress of		12	Garnet for Funer	Valley, PA
Ba perm Dept Imp		Bust !	List Co	usma	5		103 W.	St	ockton	Street,	Elkton, M	D 21921
Physician // // // // // // // // // // // // //		23a. Part I. Enter the diseas failure. List only one ca	use on each line.				-	ring, su	ich as cardiac	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disc or condition resulting in dea		Injuries con or as a conseq			ning					Dodai
	- e	Sequentially list conditions, if any, leading to immediate		or as a conseq	uence of)	:						
	티	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):										
6 be executed ysician and bunial - transit	<u> </u>		d									
		UNPENDED  FFEMALE:	AMEN	IDED If yes, outcome	of prean	ancv					23d. Date of deliver	<u> </u>
Box 6876( c death certificate the attending phys ed for use as the b	2	3b. Was decedent pregnant past 12 months?	in the 1	Live birth Pregnant at tir		2 Fe	tal death	3	Ectopic pregr	nancy		Day Year
Box a death of the atter	Physician/M	1 Yes 2 No 9	Unknown 9	Unknown	110 01 000	<sup>ttn</sup> 5	ner (Specify)					
P.O. es that the igned by be detach	2	Part II. Other significant co	iditions contrib	uting to death b	out not re	sulting in the u	nderlying cau	se give	en in Part I.		obacco use contribute to s 2 ✔ No 3 Pro	
24a. Was an autopsy performed?								utopsy findings available completion of cause of				
							rmed? death?	_				
ician: certific	90	25. Was case referred to me examiner?	dical Hospital:						Death (Check			
of Vig Phys fler this neral di		1 Yes 2 No 27. Manner of Death	28a	. Date of Injury		ER/Outpatient 28b. Time of Ir			at Work?	28d. Describe	Residence 6 Othe	
Sion Attendin death. ector: A	ation		nvestigation	(Month, Day, Xea 19 14, 2012		1500 hrs			2 🗸 No		onto rocky jetty an	
Division pital or Attent ours after death teral Director: filled in by the	Certification	3 Suicide 6 Could not be determined (Specify) Ocean  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Town, State) Walkway to Stone Breakwate						itate)				
bou hou		29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
To the within To the comple	ᄝ	29b. Signature and title of ce	and ma	inner stated.	nation an	u/or nivestigat	29c. Lic			at the time, date	29d. Date signed (Mo	
		/ X fection	6 mi				0	C.M.	E.		August 15, 2012	
151	3	Name and address of pe Laron Locke MD.					ltimore St	reet	Baltimore	MD 21223	t	·
Stat	e <sup>3</sup>	31. Date filed (Month, Day, Y	ar	32. Registrar's	Signatur		Ked		Daltimore,	1110 2 1220		
Registra		AUG 2	, 7 2012	Cenera	1 1	1. 190	1cm					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2<u>012</u> Physician/ Agnes Mary O'Brien 2 August 5:05 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Elder Care Charles LaPlata If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 31 Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Davs Min. 1 ☐ M 2 💢 F Months Hours Director 92 1919 216-12-4611 Pennsylvania Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Kenwood Place 20640 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc Yes 2 XNo 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 XWidowed 4 Divorced Year or Dates al Hygiene.
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event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk U.S. Government e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gerald Bolger Finnegan Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 st of Health a Noreen O. Sahakian Daughter 5557 First Statesman Lane, Alexandria, Va. 22312 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Aug. permit. Page 1 Department of Important: If it any injury or or 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 22, 2012 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia rlington National Cemetery 22. Name and Address of Facility
Williams Funeral Home, P.A. Signature of Funeral PIUUDOS 4270 Hawthorne Rd., Indian I sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ture. List only one cause on each line. Head, 20640 23a. Part 1. Enter the di shock, or heart fail Immediate Cause (Final Approximate Interval Between Onset and Death <u> Demento</u> Physician/ disease or condition Medical resulting in death) Due to (or as a consequence p Examiner Sequentially list conditions Examiner if a 17, leading to incrediate cause. Enter Underlying Cause (Disease or iinjury Dite to for as a consequence To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Dav 1 Yes 2 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending work 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Number determined building, etc. (Specify) Medical

State

Registrar

29a. Certifier

(Check

only one)

31. Date filed (Month

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D070900

MD 21061

29d. Date signed (Month, Day, Year) 3

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8/10/2012 ay Robert Joseph Pfeifer 23:05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 16 Long Point Ct. Berlin Worcester 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth  $\underline{\underline{M}} \overset{\text{Country})}{D}$ 9. Birthplace (State or Foreign Funeral 1**X** M 2 □ F Months Days Hours Min 11/3/1939 Director 72 218 34 1897 Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MD 1 Yes 2 X No Berlin Worcester 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 16 Long Point Ct. 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates. Nat. Guard Specify: white Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Technology Management PHH Group Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) 10 John Christian Pfeifer Marie Louise Amrhein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Pfeifer (wife) 16 Long Point Ct. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Sacred Heart of Jesus Cem 8/18/12 Baltimore, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signatury of Funeral Service Licenses 108 William St. Berlin, MD 21811 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician EMBENDOCALAE CA disease or condition Medical resulting in death) Examiner mono cowa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Dav Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 1 ☐ Yes 2 ☐ No 2 N Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 🗌 Yes 2 No မှု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ( 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one Signatur 29c. License number 29d. Date signed (Month. Day, Year) 146257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10324 or ocean city sub Bourd, up 21811 asmuent mo 10+1 State AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8/11/2012 Day 7:17 P M Harry Joseph Riley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lighthouse Court Worcester Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Days Min. Hours (Month, Day, Year) 12/30/1920 Director 072 16 4309 1 M 2 □ F 91 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar mart by metified at Director 10d. Inside City Limits Worcester Berlin 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Lighthouse Court 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 K Married Completed by 1 K Yes If Yes, Give 1 Yes 2X No Specify: 3 Widowed 4 Divorced Navv Specify: white Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lithographer self-employed Be permit. Pege 1 and 2 should be filed.
Department of Health and Mental Hy, important: If Item 27 is marked --eny injury or other tra-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Joseph Riley Alice McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris G. Riley (wife) Lighthouse Court, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) first State Crematory 8/14/2012 Millsboro, DE 21. Signature Fun al ervice License 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest allure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or **Approximate** Immediate Cause (Final Onset and Death Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Dunito (or as a nonsequence of) the Hospitel or Attending Physicien: The law requires that the deeth certificate be executed signed by the ettending physicien and defeched for use as the burlel-transit that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signal director, pege 2 should! 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 🗷 N Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ 1 Tes Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death,

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Seath 1 Natural 2 A 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one 3 🗌 Certifying Nurse Practitioner: To the pertal my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certif 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DA(13+1 COASTAL Registrar

			_ State	epartment of Health and N Certificate of Death	Mental Hygiene Reg. No. 2012 27321					
			Registrar  1. Decedent's Name (First, Middle, Last)	pertineate of Boatif	2. Date of Death 3. Time of Death					
	Physicia Medic		Elida Pedemonte		August 9, Day 2012 7:44 a M					
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death					
Service	*		Washington Adventist Hospital	Takoma Park	Montgomery					
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country)					
	Director		220-21-7900 1 □ M 2 🖾 F 83 Yr	S.	Aug. 31, 1928 Peru					
	show d at	for	10a. State 10b. County 10c. City, Town of	r Location	10d. Inside City Limits					
	Mary 28a-f otifie	Director	MD P.G. Coll	ege Park	1 ☐ Yes 2 🙀 No					
	h the	a D	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
	th wit ms 23 must	Funeral	5028 Paducah Road	20740	USA					
<b></b>	r dea or iter niner	by Fu	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 \( \text{\subset}\) Never Married 2 \( \text{\subseteq}\) Married \( \text{\lambda}\) \( \text{\lambda}\) \( \text{\lambda}\) \( \text{\lambda}\)	<ol> <li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li> </ol>	Diam't, Trinto, City					
036	s afte ral", Exan	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1 Yes 2 ☐ No Specify: Pe	ruvian Specify: White					
5-0	hour "natu dical	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (6	ecedent's Usual Occupation ive kind of work done during most of work	16b. Kind of Business/Industry					
2	hin 72 ne. than te Me	mo;	Flementary/Secondary (0-12) College (1-4 or 5+)	e. DO NOT use retired)						
5	Hygie Hygie other ant, th	Be C	17. Father's Name (First, Middle, Last)	omemaker	Own Home e (First, Middle, Maiden Surname)					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	인	Pablo Odar	Carmen						
ary	should and N is ma		19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Rura	al Route Number, City or Town, State, Zip Code)					
Σ	and 2 s Health tem 27		Hernan Raul Pedemonte/Son 50	18 Paducah Road, Co	11ege Park, MD 20740					
ore	t of Heriter		20a. Method of Disposition  1 Burial 2 KCremation 3 Removal from State  20b. Place of Disposition		Date 20c. Location - City or Town, State					
ţi.	t. Pag tmen tant: njury		4 □ Donation 5 □ Other (Specify) Metropo	Litan Crematory Aug						
Bal	permi Depar Impol any ir	1	21. Signature of Funeral Service Licensee	Francis descriptions 500 University Blyd	Funeral Home Inc W., Silver Spring, MD 20901					
			23a. Part 1. Errer the disease, or complications that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arrest, Approximate					
	Physician/		Immediate Cause (Final disease or condition	110 CANCER 1	WITH METASTA O et and Death					
	Medical Examiner		resulting in death)  Due to (or as a consequence of).							
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Box 687	th cer ttendii or use	Physician/Med	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death	23d. Date of delivery  Month Day Year						
Bo	e deal the at thed fo	WORTH Day real								
Ö.	hat the dea led by the a detached f	by Phy	g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?							
S, I	uires that signed I	1 Yes 2 No 3 Probably 4 Unknown								
ord	v requ	1   Yes   2   Mo   3   Probably								
Division of Vital Records, P.O.	nysician: The law inis certificate has to director, page 2 s	mo			autopsy performed? prior to completion of cause of death?  1 □ Yes 2 □ No					
a	ian: T	Be C	25. Was case referred to medical examiner?	26. Place of Death (Chec.						
<b>=</b>	hysic his ce al dire	은	1 Yes 2 Mo 1 Pospital: 1 Impatient 2 ER/Outp		ome 5 Residence 6 Other (Specify)					
סר	I or Attending Phys after death. Director: After this i in by the funeral d	Certificate:	27. Manner of Death  1 Datural 5 Pending (Month, Day, Year) 28b. Tin inju	ry work?	28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number,					
Sior	death death stor: / y the	tific	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes 2 No						
įχ	after after Direct	Medical Cert	4 Homicide determined building, etc. (Specify)	, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6, 6,	City or Town, State)					
-	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hour after death.  within 24 hour after death.  within 24 hour after death.  The Funeral Director: After this certificate has been signed by the attending physician of the funeral Director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 3 should be detached for use as the completely filled in by the funeral director, page 3 should be detached for use as the completely filled in by the funeral director, page 3 should be detached for use as the completely filled in by the funeral director, page 3 should be detached for use as the completely filled in by the funeral director, page 3 should be detached for use as the completely filled in by the funeral director, page 3 should be detached for use as the completely filled in by the funeral director, page 3 should be detached for use as the completely filled in by the funeral director and the completely filled in the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or i		nd due to the cause(s) and manner as stated. t the time, date and place, and due to the cause(s) and manner stated.					
	the H hin 24 the Fi	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	dge, death occurred at the time, date and pl	ace, and due to the cause(s) and manner as stated.					
	٥١١٩٩		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)					
	) "		SAAMW, MI)	De Brief)	7 3 5 (10012.					
			30. Name and address of person who completed cause of death (Item 23a) (Tyll SHAMM, WAS HUNGTOK	ADVENTIST HOSP	7 8/9(2012. TAKOMA PARK MD-20912					
	Stat Registra		31. Date filed (Month, Day, Year)  AUG 1 0 2012  Registrar's Signature	ald						

Leron Lewis Pugh		rint in Black Indelible i faryland / Department o			0010 0700	
	1- For State Registrar	Certificate o		Reg. No.	2012 2732	
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	s Pugh		2. Date of Death Month Day August 15, 2012	Year 3. Time of Death 0801 hrs	
	4a. Facility Name (if not institution, give street 12205 Northwood Drive	t and number)	4b. City, Town, or Location of Death Upper Marlboro	4c. C	County of Death nce George's	
Funeral	Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD	D/YYYY) 9. Birthplace (State or	
Director	219-17-5896 XM	2_F 33 Yrs	Months Days Hours Min.	01/16/197	79 Foreign Country) VA	
Aua	10a. State 10b. County	10c. City, Town or Loca	ion		10d. Inside City Limits	
Aaryland 28a-f show i at once. ector	MD Prince Geo	rge's Upper Mar	rlboro		1 XYes 2 No	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	10e. Street and Number 12205 Northwood D	rive	10f. Zip Code 20772		n of What Country?	
with t with t ans 23 an	11. Marital Status 12.	Vas Decedent Ever in U.S. 13. W	as Decedent of Hispanic Origin? ( Sp	ecify Yes or No-	4. Race - American Indian, Black,	
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215-( be filed virted oth reat, the ent, the Be Cc	17. Father's Name (First, Middle, Last) William Vaughn		18.Mother's Name	First, Middle, Maiden Surname)		
212 ould be d Ment s mark iic ever	19a. Informant's Name/Relationship (Type, F		g Address (Street and Number or R	_	or Town, State, Zip Code)	
MD ad 2 sh alth an m 27 is m aum at	Leasle Pugh/Mothe		Northwood Dr.		·	
Ore, ges 1 ar of Her if ite	20a. Method of Disposition  1 ** Burial 2 Cremation 3 Re	moval from State crematory or of			cation - City or Town, State	
Itim it. Pag rtment ortant:	4 Donation 5 Other Specify:  2 Signature of Funeral Service In Insee		e Cemetery 8/2		ic Funeral Home	
Depa Depa Injury	similar ( Inio				ldorf,MD.20601	
Physician	23a. Part I. Enter the disease, or complication failure. List only one cause on each line	is that caused the death. Do not enter t				
/Medical Examiner		t Ventricular Hype (or as a consequence of):	ertrophy		Death	
	Sequentially list conditions, b.	(or as a consequence or):				
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D.O. Box 68760, that the death certificate be need by the attending physici detached for use as the buriby Physician/Med	a[	Unknown  buting to death but not resulting in the	23e. Did tobacco use	e contribute to the cause of death?		
P.C. res that signed be deta				1 Yes 2 N	No 3 Probably 4 Vunknown	
Records, I The law requires ficate has been sig page 2 should be Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of	
Reco				performed? 1 ✓ Yes 2 No	death? 1 ✔ Yes 2 No	
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner? Hospita	:	26.Place of Death (Check of			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the buildedical Certification: To Be Completed by Physician/Med	3 Suicide 6 Could not be	3e. Place of Injury - At home, farm, stre	et, factory, office building, etc.	28f. Location (Street and or Town, State)	Number or Rural Route Number, City	
Hospits Plunera Flunera	4 Homicide	the best of my knowledge, death occu	rred at the time, date and place, and	due to the cause(s) and n	nanner as stated.	
To the Ho within 24 P To the Fun completely	one) 2 Medical Examiner: On the	e basis of examination and/or investiga nanner stated.	tion, in my opinion, death occurred at	the time, date and place,	, and due to the cause(s)	
2	29b. Signature and title of certifier	,	29c. License number O.C.M.E. 00		te signed (Month, Day, Year)	
	30. Name and address of person who complete	TRy Mar 23a)	J.O.IVI.E. 00	Augus		
		ssistant Medical Examiner	900 W. Baltimore Street, Ba	altimore, MD 21223	3	
State	31. Date filed (Month Pereyer) 6 2012	32. R gistrar's Signature	. V.1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMES ALBERT PAGE JR AUGUST 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 216-48-6634 1 X M 2 □ F April 3, 1946 Frederick 66 show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21703 4112 New Design Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Crop Farmer Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Ricketts James A. Page, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4112 New Design Rd., Frederick, MD 21703 19a. Informant's Name/Relationship (Type, Print) Jennifer Page / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Frederick, Maryland Manor Reformed 8/10/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live Birth
4 ☐ Pregnant
9 ☐ Unknown in the past 12 months? Month Day Year Pregnant at time of death signed by the a'd be detached for Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy s certificate has director, page 2 performed death? 2 🗌 No 1 🗌 Yes Yes Be ( 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? \_\_\_1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural iniury 5 Pending neral Director: A Accident Investigation 3 Suicide 4 Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check within 2 only one) 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

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Registrar

State

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 0 2012

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 27324 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ROBERT FRANKLIN RUDD 15,2012 11:10AM August Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Centet Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 57271947 MD ( 219-42-5150 **Director** 1 🛛 M 2 🗆 F 65 Usual Residence of Decedent show ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Delta PAYork 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 17314 81 High Ridge Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1X Yes 2 No Black White, etc. 1 Never Married 2 X Married 1 Yes 2 X No Specify: If Yes, Give 1.966-70 Year or Date 1.966-70 Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry uld be filed within 7 I Mental Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (Figt, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary M. Alder permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elerie Rudd/Wife 81 High Ridge Road, Delta, PA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (SpecIntombment Harf.Mem.Gdns. 8/18/2012 Aberdeen, MD Signature of Funeral Se 22. Name and Address of Facility
Harkins Funeral Home, Inc., Delta, PA cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ancer Medical Due to (or as a con equence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence oi). Exami that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Dav Year signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Ses 2 No 3 Probably 4 Unknown entension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed this certificate 1 Yes 2 No Be ( 25. Was case referred t edical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes/ 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 Pending e Hospital or Attendi 124 hours after death e Funeral Director: A pletely filled in by the f Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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State of Maryland / Department of Health and Mental Hygiene? 1 For State Registrar Certificate of Death Reg. No. Decedent's Name (First\_Middle\_Last) 2. Date of Death 3. Time of Death August Physician/ Thomas James Russell TTT 2012 4:24  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10005 Maple Leaf Drive Montgomery Village Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Director 437-60-1051 1 X M 2 □ F 68 8/25/1943 Louisiana Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 10005 Maple Leaf Drive 20886 United States r than "natural", or items the Medical Examiner mu death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes, Give within 72 hours after Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced Specify: Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Federal Government Physicist other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve Thomas James Russell Edwina Marjorie Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mayra Russell(Spouse) 10005 Maple Leaf Drive, Montgomery Village, MD 20b. Place of Disposition (Name of cemetery, crematory or other place).
Metropolitan
Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 XCremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Signature of Funeral Service Licensee 22. Name and Address of Facility
DeVol Funeral Home,
Gaithersburg, 10 East Deer Park Drive, Weller 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage Liver Disease Medical resulting in death) Due to (or as a consequence of Examiner Cirrhosis of the Liver Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to lor as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the hurial Medical certificate be Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Linknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas certificate 1 Yes 2 No 1 ☐ Yes 2 😾 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) Hospital: 2 **X**No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.
Funeral Director: After this efely filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 🗆 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

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completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier P 29c. License number 29d. Date signed (Month, Day, Year) 10 D37142 August 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Coleman M.D., 1355 Piccard Drive, Rockville, MD 20850

State Registrar

31. Date filed (Manth, Day, Year) **AUG 1** 0 2012

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Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 08 Month Physician/ 7:50 P M Marian Juanita Radtke 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4745 Lark Haven Drive Pomfret Charles If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Hours Min (Month, Day, Year) Director 577-36-5083 1 🗆 M 2 😿 F ጸን 01-01-1930 Washington D.C 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 TNo Maryland Charles Pomfret 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20675 4745 Lark Haven Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married 1 Yes 2X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 X Widowed 4 Divorced Completed Year or Dates White other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 2 should be filed with hand Mental Hygien 7 is marked other tt <u>Waitress</u> Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James W. Vaughn Mattie M. Shanholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health s : If item 27 i Harvey E. Radtke / Step-Son 4745 Lark Haven Dr. Pomfret, Marvland 20675 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery | 08-10-2012 Suitland, Maryland 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. Signature of Funeral Service Licensee will. M00945 211 St. Mary's Ave. La Plata, Maryland 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ OVYCCE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami and -tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 Yes 2 No Yes 2 Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1-Natural 5 Pending work' n 24 hours are not no Euneral Director: After an etely filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year,

State Registrar

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2 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, F DOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #26 per MD FCHD TM 8/10/12
State of Maryland / Department of Health and Mental Hygiene 20 | 2

27327 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7/17/2012 Physician/ 9:00AM Riley Segurn Dawn Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick 2125 Collingwood Lane 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**X Months Days Hours Min. Country 11697193791936 Director 230-46-2116 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Lovettsville 10d. Inside City Limits 10b. County 10a State filed within 72 hours after death with the Maryland Director VA Loudoun 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20180 14290 Purcellville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) <u>The Home</u> 8 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ld be file Mental F permit. Page 1 and 2 should be.
Department of Health and Mental Important; If item 27 is marany injury or other. 2 Ruth Elaine Cornelius Thomas Jefferson Rickett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15324 Norwood Ave, Blue Ridge Summit, Kathy Puskarich Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Hillsboro 4 Donation 5 Other (Specify) 7/20/2012|Hillsboro, VA Signature of Paneral Service Licensee 22. Name and Address of Facility Hall Funeral Home, Inc 896, Purcellville, <u>VA 20134</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARCINOM Immediate Cause (Final Physician/ Es disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Day Pregnant at time of death page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Daughter's Daughter's Other (Specify) Residence examiner? Hospital 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 
Nursing Home this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: after death. Director: After I 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one To the nd title of certifier 29b. Signature a 29d. Date signed (Month, Day, Year) any eppa ON 010104261 LIESBURG, VA 20176 30. Name and address of who completed cause of d 23a) (Type, Print) 6 RIVERSIDE PARKWA. RANGAPPA ENORA 44055 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State AUG 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 dent's Name (First, Middle, Last) 2. Date of Death Physician/ Months 0620 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8236 Hortonia Point Drive Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth Days (Month, Day, Year) Min. **Director** 577-46-9640 1 □ M 2 🖾 F 77 January 31, 1935 Washington, DC Usual Residence of Decedent or than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 3925 Oliver Street 20782 USA daath 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hyglane. Elementary/Secondary (0-12) College (1-4 or 5+) Banking 12 Bank Teller a 1 and 2 should be filed wit of Health and Mental Hygla If itam 27 Is marked other or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara M. Demers Alphonse Letourneau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward F. Ryan / Husband 3925 Oliver Street, Hyattsville, MD 20782 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) parmit. Paga 1 a Depertment of H Important: If ital any injury or oth 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 8/11/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to for as a consequence of Examiner ONG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury sician and burial-transit Hospitel or Attending Physician: The law raquiras that the death cartificate be exacuted MURRHAGE that initiated events Due to (or as a consequence of): resulting in death) Last attanding physician Physician/Medical Box 68760 tha use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ō Dav Pregnant at time of death 5 Other (specify) ed by tha a g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HIST 2000 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No Yes 2 No diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence RESIDENCE 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA funaral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After work? 1 🗆 Yes 2 🗆 No Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by tha fu ☐ Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Signature and title of certif ٥ 10 JW ame and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE M M 445 31. Date filed (Month, Day, Year) State G 1 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 2 per doc 931 9-21-12 vt
State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 12 2012<sup>ea</sup> 1:15 Αм Vera Simon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Homewood at Crumland Farms 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral England Month, Day, Year, 1923 Days Hours 89 114-28-4311 Director 1 □ M 2 🗓 F Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director Maryland Frederick Myersville 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 3202 D Ward Kline Road 21773 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education Librarian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lillian Lindsey Thomas Henry Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3202 D Ward Kline Road, Myersville, MD 21773 <u>Deborah LaGarde / Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Rocky Gap Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State August 16, 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 2012 Flintstone, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Startord PA Funeral Home MO1473 106 E. Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused shock, or heart failurg. List only one cause on each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 400 ras Sequentially list conditions, Examine if any, leading to infinediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Dav 5 Other (specify) ☐ Pregnant at time of death a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hyperlj podensa 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🛱 No Other: ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 55/04 12 ans 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JV Gail Griffin, M.D. 1520 South Main Street, Mount Airy, Maryland 21771 31. Date filed (Month, Day, Year). AUG 2 7 2012 Registrar's Signa

Registrar DHMH 17 Rev 06-2011

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 27330 State of Maryland / Department of Hoolth and Maryland / Department of Hoolth and Maryland

ohn Andrew Schimoler State of Maryland / Department of Health and Mental Hygiene  1- For State Certificate of Death Registrar  Reg. No.													
Physici		1. Decedent's Name (First, Middl								2. Date of Dea	ath		3. Time of Death
Medical Exam	iner					T4: 0::	Town and			Month August 12	2, 2012 4c. County o		0744 hrs
_		4a. Facility Name (if not institutio 438 Poplar Leaf Drive		,			Town, or Le	ocation of	Death		Anne Art		
Funeral		5. Social Security Number		je (In yrs. i	last birthday)	) If Unc	der 1 Year	If Under	24Hrs.	8. Date of Bi	irth(MM/DD/YYYY)		
Director		066-46-3952	1 X M 2 F	50	,	Yrs. Month	hs Days	Hours	Min.	07/08	3/1962	Foreig Cou	<sub>untry)</sub> New York
_		Usual Residence of Decedent		T				L					
w any		10a. State 10b. County Maryland Anne	Arundel	1 '	Town or Lo								10d. Inside City Limits  1 Yes 2 No
Maryland 28a-f show d at once.	tor	10e. Street and Number	AT UNCE		— — —	10f. Zip	n Code				10g. Citizen of Wh	at Cour	
ith the Maryland 23a or 28a-f sho notified at once.	Director	438 Poplar Leaf	Drive				21037			l l	United S		-
with th 18 23a e noti		11. Marital Status	12. Was Decedent	Ever in U	.S. 13. 1			anic Origir	1? ( Sper	cify Yes or No			can Indian, Black,
death r	Funeral	1 Never Married 2 X Ma	arried Armed Forces?		1	If Yes, speci	ify Cuban, I	Mexican, P	ouerto R	ican, etc.)	White		
hours after death with the Maryland natural", nr Items 23a or 28a-f she Examizer must be notified at once	by F		orced If Yes, Give Year or Dates:			Yes 2					Specify:		
hours 'natur Exam	per	15. Decedent's Education (Spec				dent's Usual g most of wo					16b. Kind of Bus	iness/li	ndustry
	pie	Elementary/Secondary (0-12)	College (1-4 or 9	5+)	Field	d Supe	erinte	enden	t		Commercia	al C	onstruction
21215-0036 uld be filed within 72 hours al Mental Hygiene. marked nither than "natural c event, the Medical Examis	Completed	17. Father's Name (First, Middle,				-				First, Middle,	Maiden Surname)		
21215 uld be file Mental H marked 1	Be	Louis Charles S			2541000			Beatr:				04 54	
2 21 should and Me	£	19a. Informant's Name/Relations Jane E. Schimol									mber, City or Town vater, MD		
imore, MD 2 Pages 1 and 2 shou ment of Health and N tant: If item 27 is n or other traumatic		20a. Method of Disposition	-CI / WIIC	20b.	Place of Disp	_				Date	20c. Location -		
Oreges 1. trof H		1 Burial 2 X Cremation		ate	crematory or	other place	<del>&gt;</del> )					-	
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		4 Donation 5 Other Sp	Donation 5 Other Specify: Kalas Crematory 08/16/2012 Edgewater,  Signs to of Funeral Ryl Liceasee 222. Name and Address of Facility George P. Kalas Funer 2973 Solomons Island Road, Edgewater										•
Dem Dep		White lill	lll		1 2	2973 S	3o1oma	ons I	Geor slan	ge r. d Road	Kalas ru I. Edgewa	iner iter	ат ноme . MD 21037
Physician		23a. Part I. Enter the disease, or failure. List only one cause		the death	. Do not ente	er the mode	of dying, s	uch as card	diac or re	espiratory arr	est, shock, or hea	.rt	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a Cardiac A			assoc	<u>iated</u>	with	ca	rdiome	galy		Death
		or condition resulting in death)	Due to (or as a conse	equence o	·f):								
	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence o	nf):								
10	Examiner	c. Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
executed an and al - transit		ever to resulting in deathy East.	d										
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lox 68760 leath certificate be attending physi for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcon	ne of preg	(many	Catal death	3	Ectopic p	regnanc		23d, Date of o		eay Year
Box 6876( death certificate the attending phy deator use as the b	iciar	past 12 months?	4 Pregnant at	time of de	ooth =	Fetal death Other (Spe	_	_Ecropic p	regi ai io	У	Wichian	D	ay rear
프 중 출청	Physician/Me		9 Unknown							1			
s, P.O. ires that the signed by the	9 P	Part II. Other significant conditi		n but not re	esulting in the	e underlying	j cause giv	en in Part	l.			_	the cause of death?  ably 4  Unknown
Division of Vital Records, P.O in later attending Physician: The law requires that the after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	ted	Chronic Alcol	holism						—	24a. Was			topsy findings available
cords law requi	Completed										osy pr orm <u>ed</u> ? de		ompletion of cause of
tal Rec		25. Was case referred to medical					26 Diago a	of Death (C	hadi on	1 Yes	2 No 1	<b>✓</b> Ye:	s 2 No
Vital F hysician: this certifi I director.	Be C	examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpatie			thor -			Residence 6	Other:	Scene
of \ling Phy	2	27. Manner of Death	28a. Date of Inju (Month, Day,Yo		28b. Time o	of Injury	28c. Injury	at Work?	28	3d. Describe	how injury occurre	d	
ion of tending Pheath.	atio	1 X Natural 5 Pend 2 Accident Inves		ou,,			1 Ye	s 2 N	lo				
Divisior pital or Attend ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could	d not be 28e. Place of Inj	jury - At ho	ome, farm, st	reet, factory	, office bui	Iding, etc.	28	8f. Location (S or Town, S		r or Rur	ral Route Number, City
ospital hours ineral y fillec		4 Homicide	mined (Specify)										
Di To the Hospital of within 24 hours at To the Funeral I	Medical	(Check only	nysician: To the best of my miner:On the basis of exar	_									
To wit	Mec	29b. Signature and title of certifier	and manner stated.			290	c. License r	number			29d, Date signe	d (Mon	th, Day, Year)
		hing h	~ L				O.C.M	.E.			August 13, 2	2012	
		30. Name and address of person	·		,								
		Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
S: Regis	State 31. Date filed (Month, Day, Year) 2012 32. fegistrar's Signature for the state of the stat												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 27331 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8/2/2012 Year 7:25 A Gregg G. Siano Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Mir **Director** 168 46 5930 1 🗶 M 2 🗆 F 57 Yrs. 2/18/1955 PA Usual Residence of Deced or 28a-f show notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes No Marple TWP PA Delaware 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a o the Medical Examiner must be Funeral 111 Springton Mews Circle 19063 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: white 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) 4 College (1-4 or 5+) Elementary/Secondary (0-12) store owner Automotive parts/sales Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of မ Ralph Siano Rita DiLoretto 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is usually injury or any i Christine Siano (wife) 111 Springton Mews Circle Marple TWP 19063 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State D'Anjolell Crematory 8/9/2012 4 ☐ Donation 5 ☐ Other (Specify) Frazer, PA 22. Name and Address of Facility 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Part 1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ear ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a consequence of): Examiner We to (or as a consequence of): Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Status Epilosy Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ ↑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred

regg D110 State

Hospital or Attending

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Signo

Christopher Kim

29b. Signature and title of certifie

2 Accident
3 Suicide

4 Homicide

29a. Certifier

(Check

only one)

9733 Healthway Dr. Berlin, MD 21811

31. Date filed (Month, Day,

AUG 1

5 Pending Investigation

6 Could not be

determined

32. Refistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical

injury

1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

work?

Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

40068814

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month. Day, Year)

2012

City or Town, State)

				State of Marylar	nd / Depa	artment of H	lealth and	Mental Hy	giene		
			1 - State Registrar		Cer	tificate of E	Death		Reg. No.?	12	27332
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath C		3. Time of Death
	Physicia Medic		Dorothy P.	Seleski				Month August	6, 201	Year	10:00 am
· · · ·	Examir		4a. Facility Name (if not institution, give str	eet and number)		4b. City, Town, or	Location of Dea			ty of Death	1 10.00
لر			18800 Quarrymen Ter	rrace			keville_		100	0.20	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hr	S. 8. Date of Birt		ntgom 9. Birthi	place (State or Foreign
м	Director		199-14-6573	M 21€ F 86	Yrs.	Months Days	Hours Mir	(		Coun	ntry)
	*		Usual Residence of Decedent					June 3,	1926	Penr	nsylvania
	sho d	ţō	10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				1	10d. Inside City Limits
	Mar)	irec	MD Montgome	ry Br	ookevi.	11e				ŀ	1 ☐ Yes 2√12 No
	the g	10	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?
	S 23	Funeral Director	18800 Quarrymen T	errace		2083	3		USA		
	item Item	Ē	11. Marital Status	2. Was Decedent Ever in U. Armed Forces?		Vas Decedent of Hi	spanic Origin? (9	Specify Yes or No-	14. Ra	ce - Americ	can Indian,
9	ter o	þ	1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give		f Yes, specify Cuba ☐ Yes 2 🖺 No		nto rican, etc.)		ack, White, o	
ö	urs a	ted	3 <sup>™</sup> Widowed 4 □ Divorced	Year or Dates.		tes 2 Et No	<i>ъресну:</i>		Specif	<sub>y:</sub> Whit	LE
5	2 hg	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupa kind of work done d	ation Turing most of we	orkina	16b. Kind of E	3usiness/In	dustry
12	thin 7	팃	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. D	O NOT use retired)	· ·	9			
Ö	d wil	Be		3	Reg	<u>lstered</u> N			Medic	_	
JE .	e file Hear ed o	잍	17. Father's Name (First, Middle, Last) John Papson					arne (First, Middle,		ne)	
ž	Mer Mer nark	-					Paulir	ne Kovatc	h		
ā	sho one c		19a. Informant's Name/Relationship (Type,	•		g Address (Street a					
dî	and 2		Margaret M. Seleski			Quarryme	en Terra	ce, Broo	keville	, MD	20833
Baltimore, Maryland 21215-0036	permit. Pege 1 and 2 should be filed within 72 hours after deeth with the Marylend Depertment of Heeth and Mental Hygiene. Depertment of Heeth and Mental Hygiene. Depertment of Heeth 21 is marked other then "neturely", or items 23e or 28e-f show eny Injury or other treumetic event, the Medical Examitvar must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		Place of Dispo cemetery, cren	sition (Name of natory or other place	e) , .	Date 1.1	20c. Location	- City or To	own, State
<u>.</u> <u>.</u>	ment ment tent:		4 ☐ Donation 5 ☐ Other (Specify)			eaven Cem	etery Au	<sup>1g</sup> 2012,	Silver	Sprin	ng, MD
<u>a</u>	permit Depert Import eny Inj once,		21. Signature of Funeral Service Licensee	_	22	Name and Address	s of Facility	s Funera			
<b>a</b>	20 = 9 9		> Mye CM way		150	U Univers	sity Blv	d. W., S	ilver S	pring.	, MD 20901
			23a. Part 1 Enter the disease, or complications shock, or heart failure. List only one	ations that caused the deat	h. Do not ente	r the mode of dying	, such as cardia	c or respiratory arr	est,		Approximate
P	nysician/	l s	Immediate Cause (Final disease or condition	Coarse	ash.	Howat	Fail	00			Interval Between Onset and Death
ji.	Medical		resulting in death)	Due to (or as a consequence		V1				$\rightarrow$	YOURS
_^	Examiner		Commence that the state of the								
		Examiner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					$\overline{}$	-
4		am	Cause (Disease or injury that initiated events c.								
5	ra ar	<u> </u>	resulting in death) Last	Due to (or as a consequ	uence of):						
09	physicien and sthe burlait trensit	edical	d.		_	_					
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Box 687	andir use		200. Was decedent pregnant	If yes, outcome of pregna		Ectopic pregnancy			23d. Da	ate of delive	ery
ဂ် ရ	d for	sick	in the past 12 months?  1  Yes 2 No	4 Pregnant at time of o		Other (specify)	y 		Me	onth	Day Year
	by th	Physiclan/M	9 Unknown	9 Unknown							
Vital Records, P.O.	been signed by the ettending particular in the strength of the strength of the strength of the second the strength of the second in the second of the strength of the second of the strength of the strength of the second of the strength of	by F	Part II. Other significant conditions contr	buting to death but not res	ulting in the u	nderlying cause give	en in Part I,	23e. Did to	bacco use con	tribute to th	e cause of death?
Š,	gls n	Pa						1 🗆 Y	es 2 XNo	3 🗆 Prot	oably 4 🗆 Unknown
0	s bee	Completed						24a. Was a	n 24b.	Were autor	osy findings available
Rec	s certificete has k	티						autop perfor	sy med?	prior to cor death?	mpletion of cause of
1 F	or, p		25. Was case referred to medical			ac Die	ce of Death (Che	1 Yes	2 No	1 Yes	2 ∐ No
/Ita	s cert	To Be	examiner? 1 ☐ Yes 2 ☑ No	pital:		Otho					
1	eral c		27. Manner of Death	28a. Date of injury	28b. Time of	28c. Injury	4 ☐ Nursing	Home 5 Neside			
בַ לַ	th.	cat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?	yes 2. □No	200. Describe in	w injury occurr	eu	
Sig	ctor by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me. farm. stre		2 110	28f. Location (Si	root and Numb	or or Pumi	Pouts Number
DIVISION OF	d Pre		4 ☐ Homicide determined	building, etc. (Specify	)			City or Town		er or nurar	Houte Number,
- sice	within 24 hours efter deeth.  To the Funerel Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physicia	ın: To the best of my knowl	edge, death o	ccurred at the time	date and place	and due to the car	use(s) and man	ner as state	ed.
1	e Fu	Je l	(Check 2 ☐ Medical Examiner:	On the basis of examination ractitioner: To the best of n	and/or investi	gation, in my opinior	<ol> <li>death occurred</li> </ol>	at the time date an	d place, and du	e to the cau	ise(s) and manner stated
5	withly comp		29b. Signature and title of certifier		,	29c. License			9d. Date signe	d (Month, E	Day, Year)
	10		1 Rus	(Ju)		Mo	D4419	57	Acor	949	1.3013
	10	ŀ	30. Name and address of person who color	pleted cause of death (Item	23a) (Tivne Pi						
			TRA Berger (	W. 1901		KS R	P. BA	ockille	, MAG	yerd	42806 I
	Stat	e	31. Date filed (Month, Day, Year)								
	Registra		AUG 1 0 2012	32. Registrar's Signat	gas						

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Amend#20bperfuneralhome8/9/ Cortificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPH CLIFTON SMALLWOOD AUGUST 2012 Medical 11:05 A<sup>M</sup> 4a. Facility Name (if not institution, give street and number, Examiner 4b. City. Town, or Location of Death 4c. County of Death RESIDENCE. 3451 MEDWAY STREET **CHARLES** INDIAN HEAD If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number . Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) **Director** 219-56-1470 1 X M 2 🗆 F 60 MAY 26, 1952 MARYLAND Usual Residence of Decedent 28a-f show the Maryland 10a. State 10b Count 10c. City, Town or Location notified at Director 10d. Inside City Limits MARYLAND CHARLES INDIAN HEAD 1 🗌 Yes 2 🕱 No ō 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? items 23a Funeral 3451 MEDWAY STREET 20640 UNITED STATES 11. Marital Status Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō þ 1X Never Married 2 Married 2 **X** No Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify "natural" Completed 3 Widowed 4 Divorced Specify: BLACK Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) l Hygiene. other than " dary (0-12) 12TH GRADE College (1-4 or 5+ PUNCHOUT SUPERVISOR CONSTRUCTION other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ည JOSEPH SMALLWOOD ESTHER KING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. GAIL LINKINS / SISTER 3790 LINKINS ROAD, INDIAN HEAD, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Dete 1 X Burial 2 Cremation 3 Removal from State OAK GROVE CHURCH CEMETERY AUGUST 10, 2012 4 Donation 5 Other (Specify) NANJEMOY, MARYLAND Signature of Funeral Service Licensee THORNTON FUNERAL HOME, 3439 LIVINGSTON ROAD, LYDIA C. THORNTON JOHNSON MO0583 HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph<sub>sician</sub> Onset and Death disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami and the burial-trai that initiated events resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ó in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform Yes 2 X No the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2 XNo Other: မ ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 🕻 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Accident after death the Investigation М 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifyipg Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signature and title 2 29c. License number 29d. Date signed (Month, Day, Year) D52289 AUGUST 8, 2012 30. Name and address of person who comp leted cause of death (Item 23a) (Type, Print) NALIN MATHUR, M.D. 11855 HOLLY LANE, SUITE 107, WALDORF, MARYLAND 20601 31. Date filed (Month distrar's Signature State AUG 0 8 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27334 State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Elaine Karen Sloper 2012 Medical August 3:00A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Medical Center Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Min. Months Days Director 577-94-1202 1 M 2 🕱 F 51 Usual Residence of Deceden 12/18/1960 Washington, DC 10a. State 10b. County 10c. City, Town or Location the Maryland notified at 10d. Inside City Limits rector 28a-f 1 🗌 Yes 2 🗶 No Maryland Charles Hughesville ō 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be with 1 Funeral 14431 Bittersweet Drive 20637 USA Page 1 and 2 should be filed within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Department of Navy 12 Personnel Analyst Be 17. Father's Name (First, Middle, Last) of Health and Mental H f item 27 is marked ot r other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) မ Charles LeRoy Ream Ruth Ruby Wignall Grasso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 201A West 20th Street North Wildwood, NJ Darlene R. Bennett sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 🔲 Burial 2 🕱 Cremation 3 🗆 Removal from State Department o Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 8/6/2012 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBrinsfield-Echols Funeral Home, P A M00817 Three Notch Road Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (r as a consequence of) -transit and that initiated events resulting in death) Last Due to (or as a consequence of): the burial physician Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 2 X No the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performe Yes 2 X No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospita 2 X No Other: 1 🗌 Yes မ 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 5 Pending (Month, Day, Year) X Natural Accident within 24 hours after death.

To the Funeral Director: All completely filled in by the fu M 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

Eric M. Ritter 2001 Medical Parkway Annapolis, MD 21401 egistrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

08

Registrar

D64057

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 28f2 Genevieve Lucille Schleigh 5:36 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1485 Chestnut Ridge Road Grantsville Garrett 8. Date of Birth (Month Day Year) Birthplace (State or Foreign Country)

V 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🕽 F 95 214-42-0395 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2 No MD Grantsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1485 Chestnut Ridge Road 21536 23a **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify. Specify: 3 ₩ Widowed 4 Divorced White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Manager Hospitality marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be John Nelson Nuce Jessie May Nicholson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 N. 4th St, Oakland, MD 21550 Carolyn Germain / Daughter Department of Health Important: If Item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 injury or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/19/2012 Oakland, MD Garrett County Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Yea 5 Other (specify) P.0. detached signed by t Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐Yes 2 No 2 🗆 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗆 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 5 ☐ Pending investigation Natural Accident 24 hours after death. Funeral Director; A 1 □Yes 2 □No completely filled in by the Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as satisfied.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State AUG 20 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:25 A M RONALD EUGENE STEYER 8 0 12 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Oakland Nursing & Rehab. Center 0akland Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 215-24-2355 Director 1 🗶 M 2 🗆 F 10/2/1924 87 Maryland ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🛣 No MO Garrett Oakland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 233 Boy Scout Road U.S.A. 21550 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) County Roads Elementary/Secondary (0-12) 12 College (1-4 or 5+) Department should be filed with and Mental Hygien 7 is marked other ti Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ella Thompson John Wesley Steyer injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is: Dale Stever/ Son 577 Boy Scout RD., Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of Galaneau Loren 2014) Leyher place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Gardens 8-12-12 Oakland, Maryland 21. Signature of Funeral Service Ucer 22. Name and Address of Facility Newman Funeral Homes, P.A. S. Second St., Oakland, MD 21550 203 23a. Part 1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events burial-trar and Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ in the past 12 months? the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has perform 1 ☐ Yes 2 🗷 No Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 2 No မ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of dertific 29c. License number 29d. Date signed (Month Day, Year)

DHMH 17 Rev 06-2011

State Registrar Oakland, MD 21550

311 N. Fourth St.,

Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Johnson MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2328M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death AAMC Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 047-28-2407 Days Director 76 1 □ M 2**XX**F 7/4/1936 Conn or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Anne Arundel Crownsville 1 Yes XX No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1042 Plum Creek Drive 21032 USA permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married XX Married Completed by 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2XX No Specify. White 3 Widowed 4 Divorced Year or Dates Item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Dental Hygienist Dental Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Jessie Narkin Edward Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Stoops Spouse 1042 Plum Creek Drive Crownsville, MD 21032 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, cemetery, crematory or other place, 1 XX urial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Our Lady Of the Fields 8/18/2012 | Millersville, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final A S V S TO UE) Onset and Death Physician Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the 9 Unknown Unknown signed by the ld be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completely filled in by the funeral director, page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to redical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) BRANDERMILL BLUD 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Bertha King Sumlar August 4:40 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min Director 226-26-4218 Falling Springs 101 1 🗆 M 2 🕱 F 06/18/1911 Usual Residence of Decedent Virginia show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f D.C. Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 229 Division Ave., N.E. U.S.A. 20019 Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2X No Specify: 3 🔀 Widowed 4 🗆 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than WRAMC Elementary/Secondary (0-12) College (1-4 or 5+) Pathology Clerk vears Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked o ပ John Lewis King Annie B. Owen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Claudia V. Owens/Niece 3413 Gloucester Rd., Richmond, Virginia 23227 f Health a 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Lincoln Mem. Cem. 08/14/12 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup>
Henry S. Washington & Sons Co., Inc.
1925 Burroughs Ave., N.E., Washington, D.C. 20019 Qroll CC0316 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysiciani vere Medical resulting in death) Due to (or as a consequence of): Examiner Winaru Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical requires that the death certificate be P.O. Box 68760 es, outcome of pregnancy
Live Birth 2 🗆 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy perform 2 🗌 No 2 XN 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attend within 24 hours after death To the Funeral Director:

2500

DHMH 17 Rev 06-2011

State Registrar

3 🗌 29b. Signature and title of certifier

MACRA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0071147

29d. Date signed (Month, Day, Year)

29c. License number

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6	- [	J	J	-

		1 - For State Registrar	State of Ma	aryland	•	tificate of				eg. No.		21003
Physici	an	Decedent's Name (First, Middle, La	st)					2.	Date of Dea Month	th Day	Yeer	3. Time of Death
/Medi		TYRENA MICHELLE							8 -	4-	2012	2:48 P M
Examir	ner	4a. Facility Name (If not institution, giv				4b. City, Town,					County of Deat	1
		3531 EVEREST DRIV 5. Social Security Number 6. S		a /la um la a	a fairstanda a	TEMPLE If Under 1 Year			Date of Birth	PG	0.0:4	
Funeral Director			TH SINE	e (In yrs. Ias 36	Yrs.	Months Days		Min.	Date of Birth (Month, Day) -5-197		9. Birti Co.	hplace (State or Foreign untry) FL
aryland ehow	_	10a. State 10b. County		· ·	Town or Lo							10d. Inside City Limits 1 Yes 2 □ No
28a-1	ectc	MD PG		3531	EVER	REST DRIV	/E					
23a or 2	Funeral Director	3531 EVEREST DRIV	/E			10f. Zip Code 20748				JS	zen of What Co	untry?
portition of the Mary state of the 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23s or 23s-1 show say injury or other traumatic event, the Medical Examinar must be neitling an appear.	by	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent (Armed Forces? 1 Yes 2 The lift Yes, Give Armed Year or Dates:			Was Decedent of I f Yes, specify Cub I ☐ Yes 2 No			y Yes or No- an, etc.)		14. Race - Ame Black, White Specify: BLA	e, etc.
72 ho	ted	15. Decedent's Ed (Specify only highest gra	ducation		16a. Deced	dent's Usual Occu kind of work done	pation	at of working		16b. Kir	nd of Business/	industry
within iene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	STUDE	DO NOT use retire	ed)	st or working	1	PRIV	ATE	
Hygiet ent,	BeC	17. Father's Name (First, Middle, Last,	4				18. Moth	er's Name (F	irst, Middle, I	Maiden	Sumame)	
Mental Mental Med tice	To B	LONNIE BEA SPRY					DOR	OTHY N	FCRTTT	г		
Shou shou	_	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	g Address (Street					Town, State. Z	'ip Code)
Ind 2 eith a 27 is		DOROTHY COLBERT/M	OTHER		3531	EVEREST	DRIVE	. TEMP	LE HII	LLS.	MD 207	48
other other		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of natory or other pla		Dete		<u>-</u>	cation - City or	
Pages nent of nt: If II		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State				1	9.10.2	012	ייידי	TAND M	TD.
mit.		21. Signature of Funeral Service Licer	1.1.	10/653	22	L CEMETE  . Name and Addre	ess of Facili	ity POPE	FUNERA	AL H	OMES, P	.A.
Deparii Deparii Impo		Vananti Ti	When	-		538 MARI						
		· 23a. Part1. Enter the disease, or com	plications that caused	the death.	Do not ent	er the mode of dyi	ing, such as	cardiac or re	spiratory arr	est,		Approximate
Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each iir		t car	3 m 0 A						Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a Due to (or as			VELL						years
Examiner			240 (0.43)	a conseque	1100 01).							
	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a conseque	nce of):			-				
uted	Examiner	Cause (Disease or injury that initiated events										
execting an an	Exa	resulting in death) Last Due to (or as a consequence of):										
ficate be executed physicien and sthe burial-transit	edical	d										
og phy as th	led											
To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours elter death.  On the Funeral Director: After this certificate has been signed by the ettending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregnanc Other (specify)	y	-		2	3d. Date of deli Month	v <b>ery</b> Day Year
thet t	by Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resulti	ng in the ur	nderlying cause gr	ven in Part 1	1.	23e. Did tot	pacco u	se contribute to	the cause of death?
equires an sig									1 □ Ye	es 2[	No 3□Pro	obably 4 Onknown
awre awre s be	Completed								24a. Was a		24b. Were au	topsy findings available
Physician: The law rithis certificete has be set director, page 2 si	E								autops perform	ned?	death?	completion of cause of 2 \( \subseteq \text{No} \)
dan: rtitice	0	25. Was case referred to medical					26. Place	e of Death (C			1 1 1 1 4 3	2 🗆 140
ysici ysici is ce direc	0 8	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatie	nt 2 EF	3/Outpatien	t 3□ DOA Ot	hac	ursing Home			Other (Spec	cify)
g P. C	T:U	27. Manner of Death	28a. Date of Injur (Month, Day	ry 2	8b. Time of	28c. Inju Wo			. Describe ho			
Attending Physician: The added to death. by the tuneral director, page	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	1	7 7 5 217	Injury		Yes 2	No				
Atte	1100	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At hom	e, farm, stre	et, factory, office		28f.	Location (St City or Town			ral Route Number.
s et s et s et s et s et s et s et s et	Certification:		bollang, oto	o. (Opecity)					Ony or rown	i, Siale)		
To the Hospital or Attending I within 24 hours elter death and To the Funerel Director: After completely tilled in by the tuner	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the ti restigation, in my	ime, date ar opinion, dea	nd place, and ath occurred a	due to the cast the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s)
To th Withir To th comp	Me	29b. Signature and title of certifier				29c. Licens			2		e signed (Month	
		> Jay Rugama	MMD			D2:	5001			08	-08-20	12
55m		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, i	Print)		JAY .	1 DOMA	W.	MO	
Sta	to	31. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	e 3	2014	4	7/1		171/		
Registr		AUG I 020	2 amus	A	Ben	Har						
DHMH 17 Rev 1/20	001	0 A - AA.	10		4.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #27, per me, g931 9-18-12 sm
State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Reg. No. 2 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 8 2012 6:56 p M Medical William Smith Sr. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 3410 Rickey Ave Temple Hills Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min (Month, Day, Year, Director 579-26-1869 1 X M 2 D F 86 Yrs. 9-11-1926 Usual Residence of Decedent PA fshow 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Prince Georges Temple Hills 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? Funeral 3410 Rickey Ave. 20748 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ģ 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) | Hygiene. other than " permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M College (1-4 or 5+) 2yrs. Elementary/Secondary (0-12) Area Regional Director Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur T. Smith Rachel Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henrietta Smith/Wife 3410 Rickey Ave. Temple Hills MD 20748 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Fort Lincoln 8-9-2012 Brentwood, Maryland fre of Funeral Se 22. Name and Address of Facility John T. Rhines Funeral Home Sign 3005 12th Street NE Washington DC 20017 M01592 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alosto gart mmediate Cause (Final Physician) Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir burial-trar resulting in death) Last Due to (or as a consequence of) physician Physician/Medical certificate be P.O. Box 68760 the attending plant for use as use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed plnods Hyperlipidemia 24b. Were autopsy findings available 24a. Was an has autops prior to completion of cause of performed? death? certificate Recent left hip fracture (5/12) 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ဨ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 A Residence 6 Other (Spe funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending work? 5 Pending injun Accident June, mil 2 No Investigation 3 Suicide 6 Could not be Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours a Funeral I Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2

To the I

comple 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) 29c. License number D0030296 8-2-2012 E Jih 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Deborah Thompson,

b

31. Date filed (Month

MD

Registrar's Signature

5100 Auth Way Suitland MD 20746

	1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 27341											
ı	Physicia		Decedent's Name (First, Middle, Last)     Doris Joan Slade		2. Date of Death Month August 5	3. Time of Death						
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death						
-	Funeral		Patuxent River Health & Rehab  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Laure 1 ) If Under 1 Year 1 if Under 24 Hr	s. 8. Date of Birth	Prince George's  9. Birthplace (State or Foreign						
l.	Director		577-40-9681 1 DM 2 NF 80 Yrs.	Months Days Hours Min	n. (Month, Day, Ye	1931 Washington, DC						
	land show dat	ţ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation.	10000	10d. Inside City Limits						
	e Mary r 28a-f notifie	Sirec	MD Prince George's Laurel			1 🖾 Yes 2 □ No						
	with the	<b>Funeral Director</b>	10e. Street and Number  14200 Laurel Park Drive	10f. Zip Code 20707	10g	g. Citizen of What Country?  USA						
	death ritems ner mu		Armed Forces?	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.						
036	s after ral", or Exami	ed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates,	1 ☐ Yes 2 🔀 No Specify:		Specify: White						
15-0	72 hour	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wo	orking 16	b. Kind of Business/Industry						
212	within jiene.		Elementary/Secondary (0-12) College (1-4 or 5+) Wait	DO NOT use retired) **Tess	Restaurants							
pue	e filed trail Hyged ed oth	To Be	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maid	den Surname)						
aryli	nould b ind Mei s mark umatic		Dennis Joseph Murphy  19a. Informant's Name/Relationship (Type, Print)  19b. Mai	Edna Ma	•	v or Town, State, Zio Code)						
Σ.	and 2 should be filed Health and Mental Hy em 27 is marked oth ther traumatic event		Catherine Watkins / Daughter P. 0	. Box 1104, Enid,		y or rown, ordio, 21p odday						
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1   Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposerer, creations of the properties of the p		c. Location - City or Town, State							
altir	ermit. P epartme iportar iy injur		rancy senior v	eterans Cemetery; 8/ 22. Name and Address of Facility		eltenham, Maryland 739 Baltimore Avenue						
m	2 G E # 9		23a. Part 1. Enter the disease, or complications that caused the death. Do not en			Myattsville, MD 20781						
m,	Physician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	c Cardiovascular		Approximate Interval Between Onset and Death						
	Medical Examiner		resulting in death)  a. After Tosc Terror.  Due to (or as a consequence of):	c Cardiovascular	Disease	Years						
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	cuted and transit	Examiner	cause. Erner Undernying Cause (Disease or injury that initiated events c.									
0	cate be executed physician and s the burial-transit	edical E	resulting in death) Last  Due to (or as a consequence of):			!						
68760	rtificate ing phy e as the	Med	IF FEMALE:									
Box 6	law requires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial-transi	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No  23c. If yes, outcome of pregnancy  1 Live Birth 2 Fetal death 3  4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year						
P.O. B	t the de by the stachec	Physi	9 ☐ Unknown									
S,	ires tha signed id be de	۵	Part II. Other significant conditions contributing to death but not resulting in the Gangrene Left Foot	underlying cause given in Part I.		co use contribute to the cause of death?  2  No 3 Probably 4  Unknown						
ord	w requ	Completed	Diabetes Mellitus		24a. Was an	24b. Were autopsy findings available						
<b>£</b>	The ate I pag				autopsy performed 1 \(\sum \) Yes 2 \(\frac{\text{Yes}}{2}\)	prior to completion of cause of death?  No 1  Yes 2  No						
/Ital	rsician s certifi director	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital:  1  Inpatient 2 ER/Outpatie	26. Place of Death (Che		a∏a, /a // /						
Division of Vital Records,	ing Phy ifter this uneral o		27. Manner of Death  1 ☒ Natural 5 ☐ Pending  1 ☒ Natural 5 ☐ Pending		28d. Describe how in	e 6  Other (Specify)						
SIOF	Attend r death ctor. A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st	M 1 Yes 2 No	28f Location /Street	and Number or Rural Route Number.						
2	ital or urs afte ral Dire		building, etc. (Specify)		City or Town, St	tate)						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check conly one)  1  Certifying Physician: To the best of my knowledge, death conly one)  2  Medical Examiner: On the basis of examination and/or investoring Nursen Practitioner: To the best of my knowledge.	stigation, in my opinion, death occurred	at the time, date and pl	ace, and due to the cause(s) and manner stated.						
	To the voithir comp		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)						
	ZJM	-	30. Name and address of person who completed cause of death (Item 23a) (Type,	53411	At	ugust 8, 2012						
			Jagdish C. Shedsadri, MD, 14300 Gall	lant Fox Lane, Boy	wie, MD 20	715						
	Stat Registra	e r	31. Date filed (Month, Day, Year) 0 2012 32 Registrar's Signature.	arka								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 9:43 PM GERRY THARP 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 220-20-7043 Director 1 🗆 M 2 💢 F 86 Usual Residence of Decedent 12/15/1925 Maryland 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. Harford Jarrettsville 5 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 3754 Federal Hill Road 21084 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. Examiner þ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give 1 ☐ Yes 2 No Specify: "natural". Specify: Completed 3 ₩ Widowed 4 Divorced White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) uld be filed within in Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 6 Housewife Home other Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) is marked မ John Krout Alice Almony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21084 permit. Page 1 and 2 sh Deportment of Health an Important: If item 27 is any njury or other trau Tharp Robert L. Federal Hill Rd. Jarrettsville, Baltimore, 20b. Place of Disposition (Name of Date 20. 20c. Location - City or Town, State Aug. cemetery, crematory or other place, 4 Donation 5 Other (Specify) Be Mem. Gardens 2012 Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E.G. Kurtz & Son Funeral P.A. Jarrettsville, Maryland Home, 23a. Part 1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) day Examiner Sequentially list conditions, if any, leading to immediate cause. Ender Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed Due to (or as a consequence of): attending physician a l for use as the burial-Physician/Medical ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. certificate has been signed irector, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ၉ 1 inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the I within 2 29c. License numbe 29d. Date signed (Month, Day, Year) 568

Registrar

State

30. Name and address of person who

completed cause of death (Item 23a) (Type, Print)

12-06195 Sean Torrance Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

ean Torrance	;	1- For State Registrar		e of Maryla			ate of Dea		a wen	tai Hyg		eg. No.	201	2 2734
Physic Medical Exam		1. Decedent's Name									Date of Dea Month August 17		Year	3. Time of Death 1530 hrs
		4a. Facility Name (if	not institution, g	ive street and nu	mber)			, Town, or	Location o		August 17	4c.	County of De	eath
Funera	1	Peninsula R 5. Social Security N		Sex Sex	7. Age (In	yrs. last birth		isbury	r If Unde	r 24Hrs.	8. Date of Bi		Vicomico	Birthplace (State or
Directo		228-11-		M 2 F	4	1	Yrs. Mor	nths Day	s Hours		5/25		Fo	reign Country) VA
any		Usual Residence of 10a. State	Decedent 10b. County		10c.	City, Town	or Location							10d. Inside City Limits
Maryland 28a-f show	٥	MD		omico		Sals	ibury							1 Yes 2 No
with the Maryland ns 23a or 28a-f sho	Director	10e. Street and Nun		3			10f. 2	Zip Code	0.1		1	0g. Citiz	en of What C	Country?
with the ns 23a	uneral	11. Marital Status		12. Was Dec		in U.S.	13. Was Dece		panic Orig			)-		nerican Indian, Black,
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Fu	1 X Never Marrie 3 Widowed		1 Yes	2 X	No	If Yes, spe			Puerto Ri	can, etc.)	White, etc.		
ours after	d b	15. Decedent's Ed		or Dates: only highest grad			1 Yes Decedent's Usu	al Occupat	ion (Give				Specify: ind of Busine	White ss/Industry
7	Completed	Elementary/Secoi	ndary (0-12)	College (1	-4 or 5+)		luring most of w	Ů	DO NOT	use retired	1)		lisbu	
15-003( filed within I Hygiene. ed other tha	၂ ၂	17. Father's Name (	First, Middle, Las	st)			Mecha		18.Mother	s Name (F	irst, Middle, I			rniture
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		Robert 19a. Informant's Nar	Eugene	Torra	nce	Lin					Rose			
	F	Debbie S	•		ther		. Mailing Addre LO Mar	- 1					•	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: Hitem 27 is n ioliury or other tranmatic		20a. Method of Disp		Removal fro		20b. Place of	f Disposition (N	ame of cer			)ate			or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite			Other Specif	fy:		irst	State		m.	8/20	/2012	A P	lills!	ooro, DE
Bal permij Depar Impo		21. Signature of Fun	eral Service Lice	onsee Olya Acad	(		22. Name an	nd Address Will	of Facility iam	Bur St.,	bage Ber	Fur lin.	neral , MD 2	Home 21811
Physiciar /Medica		23a. Part I. Enter the failure. List only	disease, or com		aused the d	leath. Do not								Approximate Interval Between Onset and
Examine		Immediate Cause (F or condition resulting		Heroin Due to (or as a			on							Death
	L		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):											
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated												
uted Id ansit	Exa													
60, ate be executed hysician and e burial - transit	Medical	X UNPENDED		AMENDED 2	3a,pt	.II,2	7,28a-f	,per	me,g	931 9	-6-12	sm		
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	In/Me	IF FEMALE: 23b. Was decedent p past 12 months?		23c. If yes, o		pregnancy 2	Fetal deat	h 3	Ectopic	pregnancy	,	- 49	Date of delive	very Day Year
Box 6876  he death certificate the attending phy hed for use as the	Physician/N	1 Yes 2 N		7	ant at time	of death 5	Other (Sp	pecify)						
P.O. E	1 4	Part II. Other signifi	cant conditions			not resulting	in the underlyin	ng cause g	iven in Par	rt I.				to the cause of death?
v requires the speen signer should be d	Completed by	Congeni	tal Hea	rt Disea	se					_	1 Yes			robably 4 Unknown autopsy findings available
of Vital Records, ag Physiciae. The law require this certificate has been someral director, page 2 should let	mple							<u> </u>		<del></del>	autop perfo	sy m <u>ed</u> ?	prior f death	to completion of cause of
tal Rection: The certificate ector, page	e Co	25. Was case referre	ed to medical							Check only	1 Yes	2 No	1 🗸	Yes 2 No
of Vital I ling Physiciae: After this certifi funeral director.	To Be		No				tpatient 3					Residen		her:
ion of tending leath. tor: Afte	tion:	27. Manner of Death  1 Natural	5 Pending		Day,Year)		ime of Injury  2:00 am	400	yatWork? 'es 2 🗶		d. Describe I nknown		ry occurred	
ViS or At fler d in by	iji	2 Accident 3 Suicide	Investiga 6 X Could no	t be 28e. Place			m, street, facto		uilding, etc	28	f. Location (S	Street an	d Number or	Rural Route Number, City
Di lospital of l hours at uneral I		4 Homicide 29a. Certifier	determine	ed (Specify)	12.13		drivewa		to and alo	S	alisbu	ıry,	MD.	
To the Hos within 24 h To the Fur completely	Medical			er: On the basis of and manner st	f examinati									
F × F S	Me	29b. Signature and	tle of certifier				2	9c. License		•				Month, Day, Year)
		30. Name and addre	ss of person who	completed caus	e of death	(Item 23a)		O.C.N	/1.□.			Augl	ust 18, 20°	14
		Donna M. Vii		Assistant N			900 W. Ba	altimore	Street,	Baltimor	e, MD 21	223		
Peni		31. Date filed (Month	Day, Year)	0019 32. R	gistrar's Sig	nature	bake	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death OFA GE0198 6. Sex Birthplace State or Foreign Country) 7. Age (In yrs. last birthday) Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days 83 **Director** 217-34-0509 1 M 2 XF Maryland 3-30-1929 with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ¥ Yes 2 □ No Maryland Prince George Brandywine ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or Funeral 20613 USA 6205 Floral Park Rd 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. ь þ 1 Never Married 2 Married altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No Specify Specify: "natural" 3 Widowed 4 Divorced Completed Black Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Prince George Bd Elementary/Secondary (0-12) College (1-4 or 5+) 12 Domestic Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) Ith and Mental H
27 is marked of
traumatic ever ပ္ Hawkins Sr Margaret Jackson Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 is / or other trai Floral Park Rd, Brandywine MD 20613 Pearline Shirriel/Daughter6205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Department or Important: If any injury or once. Union Bethel A.M.E 8-11-12 Brandywine Maryland 4 Donation 5 Other (Specify) of Funeral Ser 22. Name and Address of Facility Signatu Adams Funeral Home P.A Aquasco MD 20608 Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph\_sici\_n olon Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** months Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or sels, consequence of) Exami and burlal-trar resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2'No 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ signed by the atte d be detached for Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 1 ☐ Yes 2 🔀 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director; I I or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number

Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed

AUG O

wardyard

Rd # 101 Cleaton

of death (Item 23a) (Type, Print)

8926

08-07-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mend #18 per FH g932 10/04/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Day 10 Physician/ Vera Blanche Tichnell 11:30 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Dennett Road Manor Nursing Home Oakland Birthplace (State or Foreign Country)

WV 5. Social Security Number 6. Sex If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Hours Months Days (Mort)/23/1922 1 M 2 K F 89 215-16-4628 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director MD Garrett Oakland 1 X Yes 2 No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1113 Mary Drive 21550 **USA** items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. o. Completed by 1 Never Married 2 Married Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Hygiene. 3 X Widowed 4 ☐ Divorced Specify. White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home is marked other Be 18. Mother's Name (First, Middle, Maiden Surname)
Soelters
Alice Edith Mae Selters 17. Father's Name (First, Middle, Last) and Mental ပ္ Bert Millison Welch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is 109 Frazee Estates, Oakland, MD 21550 Dawn Panther / Daughter any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date Department of Important: If it cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 08/13/2012 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Gardens Crematory Kingwood, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Outset and Death Physician/ angrene MONITA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed physician the burial Physician/Medical iding p IE EEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year ☐ Pregnant at time of death☐ Unknown 1 ☐ Yes 2 t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page death? certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 20 မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 🕻 28d. Describe how injury occurred Certificate: work? 5 Pending injury 2 No Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 🔎 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or 29d. Date signed (Month, Day, Year) 110

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

who completed cause of death (Item 23a) (Type, Print)

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Doris Marie Wallace 1615 August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Elkton Care and Rehabilitation Cecil E1kton If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours Min April 20, West Virginia **Director** 489-30-3202 Usual Residence of Decedent or 28a-f show notified at show 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country ural", or items 23a or Examiner must be Funeral 1 Price Drive 21921 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 💢 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", Completed 3 X Widowed 4 Divorced Specify: White injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene.
7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurses Assistant Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John H. Mitchell Vergie Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or any Brenda Sue Daniels/Daughter 800 Abbott Drive, Apt. 800, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State August A. Ferris & Co., Inc. 4 Donation 5 Other (Specify) 20**I**2 West Chester, 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signa e of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ony o cond disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner quantially list nonditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami and Due to (or as a consequence of resulting in death) Last burial Physician/Medical that the death certificate be the attending phy as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Dav Pregnant at time of death by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops page certificate 1 ☐ Yes 2 ☐ No Yes Hospital or Attending Physician; Be 25. Was case referred to medical 26. Place of eath (Check only one) Hospital: Other 2 **7** 1 Tyes 은 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify this funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work?
1 Yes 2  $\square$  No Investigation the Funeral Director: npleted filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medica! Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 2012

State

31. Date filed (Me

west man st

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 | 27347
State of Maryland / Department of Health and Mental Hydiene

Snannon Nicho	ole v	1-For State Registrar  State of Maryland / Department of Health and Mental Hyc		Mo	
Physician/ Med	ical	1. Decedent's Name (First, Middle,Last)	Date of Death	, No.	3. Time of Death
Exam	iner		Month August 10,	Day Year 2012	0852 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Logation of Death  1690 Glebe Road  Earleville		4c. County of Deal	th
Funeral	-		8. Date of Birth	Cecil (MM/DD/YYYY) 9. B	irthplace (State or Foreign
Director		193700798 1 M 2 F 23 Yrs. Months Days Hours Min.	T.1.	С	ountry)
		Usual Residence of Decedent	JULY	1,1989	PA.
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
rland -f sho	tor	MD Cecil EARLEVILLE			1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	10g	j. Citizen of What Cou	intry?
ith th			ifu You or No	USA	day for Clark
eath v item	Funeral	1 Never Married 2 Married Proces? 1 Yes 2 No	can, etc.)	White, etc.	rican Indian, Black,
after dall, or	by F	3 Vidowed 4 Divorced if yes, give Year 1 Yes 2 No specify:		Specify:	hite.
hours aft. "natural" Examine				6b. Kind of Business/	Industry
36 him 72 e than "	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	·		
ed with	Completed	DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (Fir	rst, Middle, Mai	den Surname)	
21215-0036  Metal Hygiene - marked duther than "natural", or items 23s or 28s-f since corent, the Metalel Expense.	Be (		ucia	P. EA	RICKSON, Zip Code)
	2	19a. Informant's Name/Relationship (Type, Pnnt ) Mother 19b. Mailing Address (Street and Number or Rur	ral Route Numbe	er, City or Town, State	, Zip Code)
Baltimore, MD 2 vernit Pages 1 and 2 shou Oepartment of Health and 1 important: If tern 27 is r injury or other traumatic		20a. Method of Disposition 120b. Place of Disposition (Name of cemetery, D	EARL		MD21919
Baltimore, M pernit. Pages 1 and 2 Department of Health Important: If ttem 2 Injury or other traus		1 Buriel 2 Cremation 3 Removal from State crematory or other place)	yate ,	20c. Location - City or	Town, State
			18 2012	Lenns Gv	ove, NJ
Balt permit Depart Import injury		108 William St.,		Funeral in. MD 2	181)
Physician		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respective. List only one cause on each line.			Approximate Interval
/Medical Examiner		Immediate Cause (Final disease a Combined drug (oxycodone and alprazolam	)Intoxi	ication	Between Onset and Deeth
march the		or condition resulting in death)  Due to (or as a consequence of):			
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cause, Enter Underlying Cause (C) (Disease or injury that initiated  C) (Disease or injury that inju			
uted		· O			
3760, ficate be executed g play sician and sthe burial - transit	/Medical	☑ UNPENDED ☐ AMENDED 23a,pt.II,27,28a-f,per me,g931 9	9-28-12	sm	
8760, ificate be ig physic	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery	
C 68 certif			′	Month [	Day Yeer
Box 68 le death cert the attendin ted for use a	Physicial	1 Yes 2 No 9 X Unknown 9 Unknown			
that the			1	cco use contribute to t	
S, F.	pa	Diabetes mellitus with complications		2 No 3 Frob	
COFC law re- has be	ple		24a. Was an autopsy	prior to	topsy findings available completion of cause of
Rec The ficate	Completed by		performe 1 Yes 2	ed? death? X No 1 Ye	s 2 X No
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rape death.  The records of the this certificate has been signed by led in by the funeral director, page 2 should be cleach	Be	25. Was case reterred to medical examiner?		sidence 6 X Other	
of V g Phy fler th	라	27 Manner of Death 128a Date of Journ 129h Time of Journ 120a John at Manda		injury occurred	Scene
ion tendin eath. or: A	Certification:	1   Natural 5   Pending   fd 8-10-12   fd 08:10 am   1   Yes 2 \ No   No	ıknown		
IVIS or At after d Direct In by	iffice	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f	f. Location (Stre	et and Number or Rur	al Route Number, City  e Rd.
Dospital hours meral y filled	Ce	4 Homicide determined (Specify) Home			- Nu.
Division of Vital Records, P.O. Box 68 To the Hosp ital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	293. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.	to the cause(s) a time, date and p	and manner as stated. Nace, and due to the c	ause(s)
To To com	Med	and manner stated.  29b. Signature and title of certifier 29c. License number		9d. Date signed (Mor	
		O.C.M.E. OCME		August 11, 201	
OKINA	H	30. Name and address of person who completed cause of death (Item 23a)			
BA3 pending		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore	ore, MD 212	223	
Sta Registi	ate rar	DANGER OF THE CONTRACT OF THE			
DHMH 17 Rev 1/200		ORIGINAL			

			State of Maryland / Dep	artment of Health and N rtificate of Death	, ,	iene eg. N 2012	27348	
			Registrar  1. Decedent's Name (First, Middle, Last)	tineate of Beatin	2. Date of Death	1	3. Time of Death	
	Physicia Medic		Grace C. Weltman		August	: 7° 2012 ar	5:30 A M	
Alexander .	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat		
			Bedford Court  5. Social Security Number	Silver Spring  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Montgom	hplace (State or Foreign	
	Funeral Director		577-05-4127   1 □ M 2 対 F   Yrs.	Months Days Hours Min.	(Month, Day,	Day, Year) Country)		
			Usual Residence of Decedent 95		01/09/1	.917   Can	ada	
	ryland -f sho ied at	ctor	10a. State 10b. County 10c. City, Town or Lo  Maryland Montgomery Olney	ecation			10d. Inside City Limits 1 Y Yes 2 □ No	
	or 28a notif	Dire	10e. Street and Number	10f. Zip Code		0g. Citizen of What Co		
	with the 23a cast be	eral	4635 Weston Place	20832		Jnited Stat		
	items items er mu	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer	rican Indian,	
36	after or I", or kamir	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 🖾 No Specify:	indan, dio.j	Black, White		
21215-0036	atura ical E	letec	15. Decedent's Education 16a, Dece	dent's Usual Occupation		16b. Kind of Business/	ite	
215	n 72 h e. ian "n Medi	dmo	(Specify only highest grade completed) (Give	kind of work done during most of worki O NOT use retired)	na	Jnited Stat	*	
7	l withi ygiene her th t, the		12 Se	cretary	I	Department	of Commerce	
Baltimore, Maryland	ntal H ed ot ed ot	To Be	17. Father's Name (First, Middle, Last)  Albert Carmen	18. Mother's Name		aiden Surname)		
2	should be file h and Mental H 7 is marked o raumatic eve			ng Address (Street and Number or Rura		City or Town State 7in	Code	
Š	d 2 sh alth ar 1 27 is er trau			Weston Place Olne			Godey	
ore,	of Her of Her fitem		20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cre.	osition (Name of natory or other place)	Date 2	20c. Location - City or	Town, State	
Ē	Page tment tant; I		4 Donation 5 Other (Specify) National	l Crematory 8/9/		alls Churc	h, Va	
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2. Name and Address of Facility $f Jos 5130$ Wisconsin Ave	-		20016	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arres	st,	Approximate Interval Between	
, <b>F</b>	hyuician/		Immediate Cause (Final disease or condition and the condition are sensitive in death)	Arrest		2	Onset and Death	
-	Medical Examiner		resulting in death)  Due to (or as a consequence of):	Amehrethmi				
		Jer	Sequentially list conditions, if any, leading to immediate b. Ischemic Cardiac Due to (or as a consequence of):	Allinytimia				
	d d	amii	cause. Enter Underlying Cause (Disease or injury that initiated events  c.  Hypertension			4		
	e exec	dical Examiner	resulting in death) Last					
9	icate be executed grant and as the burial contractions.	dic	d				-	
Box 687	eath certifica attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deli	iven.	
XOX	eath c s atter d for u	icial	in the past 12 months?  1 ☐ Live Birth 2 ☐ Fetal death 3 L 1 ☐ Yes 2 🕱 No 4 ☐ Pregnant at time of death 5 [	Ectopic pregnancy Other (specify)		Month	Day Year	
Ö.	requires that the der been signed by the s should be detached	hys	g ☐ Unknown					
, P.O.	ss that igned be de	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	_	
rds	equire leen s hould	eted					obably 4 🖾 Unknown	
eco	e law i has b	Completed			24a. Was an autopsy perform	y prior to o ned? death?	opsy findings available completion of cause of	
Ä.	nysician: The law inscertificate has be director, page 2 s		25. Was case referred to medical	26. Place of Death (Check	1 🗆 Yes 2		2 No	
Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 😾 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other:		nce 6 Other (Speci	fv)	
o	iding Ph th. After thi funeral	te:	27. Manner of Death 1		28d. Describe hov			
ion	tendii Jeath. tor; Ai the fu	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No				
Division of Vital Records,	l or At after d Direct I in by	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rur State)	al Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and To the Funeral Director, After this certificate has been signed by the attending physician and accompletely filled in by the funeral director, page 2 should be detached for use as the buring the funeral director.	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation)	tigation, in my opinion, death occurred at	the time, date and	d place, and due to the o	ause(s) and manner stated.	
	o the	Ž	only one) 3 $\sqcup$ <b>Certifying Nurse Practitioner:</b> To the best of my knowledge 29b. Signature and title of certifier	, death occurred at the time, date and pla 29c. License number		cause(s) and manner as Od. Date signed (Month		
	77		1	D67092		ugust 8, 2		
	•		30. Name and address of person who completed cause of death (Item 23a) (Type, Weihan Wang, M.D. 15245 Shady Grove					
	Stat	e	31. Date filed (Month, Day, Year)  AUG 1 0 2012  22. Registrar's Signature					
	Registra							

			Plea	se Type	or Pri	nt in E	3lack	Indelib	le Inl	k. Ensure	All Copie	s Ar	e Legible	Å F M	
		For		State	e of M	arylan				Health and	Mental Hy	gien	2012	27349	3
		State Registrar		4 1)			C	ertificate	e of L	Death		Reg. N	10.		_
Physicia	n/	1. Decedent's Name	, ,		son						2. Date of De Month August		3, 2012 Year	3. Time of Death	M
Medic Examin		Luther  4a. Facility Name (if	Gay not institution					4b. City.	Town, or	r Location of Death	-		lc. County of Dea		VI
	eı	Dennett R 5. Social Security No	oad Mai	_	ing H		4   6   104   5   10-1	Oal	klan				Garret	t	
Funeral Director		233-42-8	317	1 X M 2 □	F 7. Ag	e (in yrs. ia	st birthday Yrs.	Months	Days	Hours Min.	8. Date of Bir (Month, Da 3/11/		7 We	irthplace (State or Foreig ountry) st Virginia	n L
yland if show ed at	ctor	Usual Residence of 10a. State	10b. County			10c. City	, Town or I	_ocation		_				10d. Inside City Limits	
e Mar r 28a- notifi	Dire	WV 10e. Street and Nun		ston		Au	irora	10f. Zip	Codo		- · · · · · · · · · · · · · · · · · · ·	10- /	Citizen of What C	1 X Yes 2 N	10
with th	Funeral Director	23642 Ge		ashinata	on Hi	ahwas	7	101. 219	267	05		_	J.S.A.	ountry?	
eath v	Fune	11. Marital Status	orge m	12. Was I	Decedent !	Ever in U.S		3. Was Deced	ent of Hi	ispanic Origin? (Sp	pecify Yes or No-		14. Race - Am	,	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Marri		If Yes	d Forces? Yes 2 Give or Dates.	No		1  Yes		Specify:	o nicari, etc.)		Black, Whi	ite, etc. hite	
natul	plete	(Spe		nt's Education				edent's Usua		ation during most of wor	kina	16b.	Kind of Business	Industry	
thin 73 ene. than he Me	Completed	Elementary/Seco	, , <u>, , , , , , , , , , , , , , , , , </u>	1	ge (1-4 or 5	ō+)	life.	DONOT use	retired)		9	C	oal Mini	na	
led wi Hygie other ent, tl	Be (	3 17. Father's Name (	First, Middle, I	.ast)			COa.	т гипте	<u> </u>	18. Mother's Nar	ne (First, Middle,	_		***9	
d be fill dental rrked trc ev	잍	Seamon	The	ron	Wils	on				Nora	Jane		DeWitt		
should and N is ma rauma		19a. Informant's Na								and Number or Ru					
and 2 Health em 27 ther t		Christin 20a. Method of Disp		on/Wife	e	20h B		42 GeO		Washingt	On HWY.		Location - City o		
age 1 ent of nt: If it y or o		·	☐ Cremation	3 Removal	from State	C	emetery, cr	rematory or o	ther plac		7/12		urora, W		
permit. P Departme Importar any injur once.		21. Signature of Fur				. Au							·		
B B B B B B B B B B B B B B B B B B B		Kich	are ;	I. Mal	ingl	les of	V 1			ss of Facility Ne cond St.,			MD 21550		
			rt failure. List o	complications to only one cause o	hat càuse n each line	the death	. Do not e	nter the mod		1			.0	Approximate Interval Between Onset and Death	
Physician/ Medical		Immediate Cause ( disease or conditio resulting in death)		Cer-	2652	a consequ	SCW ence of	LAS	150	chemic	= el	100	ix	25 day.	<u></u>
Examiner					5 to (01 as	a consequ	erice orj.								
7 ±	iner	Sequentially list co if any, leading to im cause. Enter Under	nmediate	b. — Due	e to (or as	a consequ	ence of):								
executed an and rial-transi	Examiner	Cause (Disease or that initiated events resulting in death) I	linjury s	c. Due	e to (or as	a consequ	ence of):								
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th cert tendin or use	ian/I	IF FEMALE: 23b. Was decedent in the past 12 r			_ive Birth	2 Feta	I death 3	Ectopic p		ру			23d. Date of de	,	
e deat the at	Physician/Medical	1 Yes 2 5 9 Unknown			Pregnant a J <b>nk</b> nown	t time of d	eath 5	☐ Other (sp	ecify)				Month	Day Year	
that th		Part II. Other signif	icant condition	ns contributing	to death b	out not resi	ulting in the	e underlying o	ause giv	ven in Part I.	23e. Did t	obacco	use contribute t	to the cause of death?	
quires en sign	Completed by	Kecuri	reat	UFA	nai	4	400	a	inx	rettor	1	Yes	2 <b>№</b> No 3 🗆 I	Probably 4 🗌 Unknow	vn
aw rec as bee	nple					<i>o</i>					24a. Was auto	psy	prior to	utopsy findings available completion of cause of	e
: The l cate h ; page											1 🗆 Yes	ormed?	No 1 ☐ Ye		
sician certifi irector	o Be	25. Was case referre examiner? 1 \square Yes 2		Hospital:	. 🗆	0 🗆	FR/0-+	i 0 \( \sigma \)	Othe	ace of Death (Che					
g Physer this	te: To	27. Manner of Death	1	28a. [	ate of injute of the desired in the least of	iry	28b. Time injury		8c. Injury	y at	28d. Describe		6 Other (Spe ury occurred	city)	
eath. or: Aft	fica	1 Natural 2 Accident 3 Suicide	5 ☐ Pendir Investig 6 ☐ Could	gation	violiti, Da	y, reary	ii ijai y	М	work	Yes 2 No					
or Att after d Direct in by	Certificate:	4 Homicide	determ	ined   286. P		ury - At ho c. (Specify,		street, factory	, office		28f. Location (3 City or Tov			ural Route Number,	
spital hours neral I										, date and place, a					
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	only one) 3	☐ Certifying							on, death occurred e time, date and pla				e cause(s) and manner sta s stated.	ited.
Vit Vit Con		29b. Signature and	title of certifier	_	1 -		//	1		e number			Date signed (Mon	th, Day, Year)	
		30. Name and add	1 house	who complete	YLO	leath (Itam	239) /Tim-		1246	4		٥/	14/12		,
		Sotiere		- //					akla	and, MD 2	21550			a.	/
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Registra	ar	AU	G 17 20	114	de	A.	190	Ver							

Casett		Pleas	e Type or Print in					_	ole.
Case# 12-0629	D.	For State Registrar	State of Marylar		artment of I tificate of I		Mental Hy	rgiene Reg. No. 2 N	12 27350
Physicia	n/	1. Decedent's Name (First, Middle, L.	ast)		, D		2. Date of De	eath	3. Time of Death
Medic	al_	Augusta 4a. Facility Name (if not institution, gir	Pearl		Ada		tuens		
Examine	er	Silvai Hospita	Sex 7. Age (In yrs.	Q last hirthday)		r Location of Death	8. Date of Bi	4c. County of	Death  B. Birthplace (State or Foreign
Funeral Director		227 50 2570	1 □ M 2 □ F 77	Yrs.	Months Days	Hours Min.	(Month, Da		Country)  NC
death with the Maryland Items 23s or 28e-f sho	Director	10a. State 10b. County NA		ty, Town or Lo Baltim					10d. Inside City Limits  1 Yes 2 □ No
ith the	ral D	10e. Street and Number 3508 Callaway	Δνα		10f. Zip Code	21215		10g. Citizen of Wha	at Country?
(n = p=	d by Funeral	11. Marital Status  1  Never Married 2  Married  3  Widowed 4  Divorced	12. Was Decedent Ever in U. Armed Forces?		Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race -	American Indian, White, etc. Black
laryland 21215-0036 should be filed within 72 hours afte and Mental Hyglene. Is marked other than "natural", sumatic event, the Medical Exart	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4 or 5+)	(Give life. D	O NOT use retired)	during most of work	ing		re City
yland 21 yland 21 lid be filed with Mental Hygien parked other tr	Be	12th grade   17. Father's Name (First, Middle, Last Jesse McCutche			Educato			, Maiden Surname)	Schools
		19a. Informant's Name/Relationship						er, City or Town, State	
15 9 2 2 5 5		20a. Method of Disposition  1 M Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, crer	sition (Name of natory or other plac	ce) ark 8/2	Date 7/2012	20c. Location - Ci	ty or Town, State
Baltimo permit. Page Department Important: I eny injury o once.		21. Signature of Funeral Service Licer		na <sup>22</sup>	Name and Addre	ss of Facility West		more, Mo	
Physician/ Medical Examiner		23a Part 1 Enter the disease, or con how, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caus if the deat one cause on each life.  BI lateral  Due to (or as a consequence)	th. Do not ente					Approximate Interval Between Onsevand Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence)	nb_ uence of):	frectu	res	T. :	1000	Caylus.
e e in in in in in in in in in in in in in	cal Examine	that initiated events resulting in death) Last	c. Due to (or de a consequence de la consequence della consequence	1	or here	Icoser	locati	y HRUS	<24h
Division of Vital Records, P.O. Box 68760 tal or Attending Physicien: The law requires that the death certificate be executed rs after death. al Director. After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burlal-transit	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnate 1 Live Birth 2 Fett 4 Pregnant at time of 9 Unknown	incy al death 3	Ectopic pregnand Other (specify)	гу		23d. Date of Month	of dailery Day Year
rds, P.O	۵	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause gi	ven in Part I.	23e. Dig	Reacco use contribu	ite to the cause of death?
Recoi	Completed					·		ppsy prio ormed? dea	re autopsy findings available or to completion of cause of th?  I Yes 2   No
Vital ysicien ysicien s certif	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital Inpatient 2	ER/Outpatier	Oth	er:		idence 6 🗆 Other (5	Specify)
Division of Vital Recc To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certificate:	27. Manner of Death  1	28a. Date of injury (Month, Day, Year) on 8/20/2	28b. Time of injury 1150 pme, farm, stre	AM 28c. Injur work 1 □	y at ? Yes 2 No	28d. Describe	how injury occurred a rolled	
Div Hospital o 24 hours af Funeral Di etely filled in	Medical C	(Check 2 Medical Exan	/sician: To the best of my know	ledge, death of and/or invest	gation, in my opinio	e, date and place, a	nd due to the c	ause(s) and manner	as stated.
vithin to the complete	_ ,	only one) 3 L Certifying Nu 29b. Signature and title of certifier	rse Practitioner: To the best of r	ny knowledge,	death occurred at t		ace, and due to	29d. Date signed (M	fonth, Day, Year)
- 3m		30. Name and address of person who			rint)	29325		०४/४/३	2012
State Registra		JAMSH & DYSON 31. Date filed (Month, Day, Year) AUG 2 8 2012	32. Registrar's Signat	ture	-1) -1. /-	sa BA	r ( largery		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 17,18 19a per fh 9931 9-7-12 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23 Day Physician/ Month 2:40 AM 3015 - 80 Medical Ming Ao 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico Itospice at the Lake oastal If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 12/06/1954 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) China X M 2 D F Director 605-50-5975 57 28e-f shov 10a. State 10b. County or than "natural", or items 23a or 28e-f sho the Medical Examiner must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director X□ Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1025 Caravan Way 21804 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2√☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 ☐ No Specify: 3 Divorced Completed Year or Dates Asian 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Pege 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na eny injury or other treumetic event, the Medic once. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Researcher Science Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zhongrong Ao Changhua ည Li 19a. Informant's Name/Relationship (Type, Print)
Chin-Hsiu Chen
Chinhsin-Chen / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1025 Caravan Way, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial A Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/27/2012 Chesapeake Crematory Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ LATRRAG AMYOTROPIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of Exam for use as the burial-transi Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year signed by the at I be detached for Pregnant at time of death 5 Other (specify) Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes No 3 Probably 4 Unknown cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Proystoran. The within 24 hours after death.

To the Funeral Director After this certificate has I completely filled in by the funeral director, page 2: autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence ၉ HOSPICA 1 Inpatient 2 ER/Outpatient 3 IDOA 6 Other (Specify) Certificate: 27. Magner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 State

Registrar

	AME	ND	#25,27.28A-F,	ase Type or PER ME G93	Print in 0.8/24/	Black Ir	ndelible Ink	t <b>. Ensu</b> lealth ar	re All Copie	s Are Leg	gible.		
		•	For State Registrar	Olulo J	// ividi yidi		tificate of D		IU Montani,	Reg. No. 2	012	27:	352
	Physicia	n/	1. Decedent's Name (First, Midd						2. Date of De	eath		3. Time of D	eath
	Medi	cal	Maria Bucc						· · · · · · · · · · · · · · · · · · ·	July 31 Day 2012 11:16p M			
	Examir	ier	4a. Facility Name (If not institution Carroll Hospic				4b. City, Town, or Westmin		Death	4c. County	of Death		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi Min. (Month, D	rth		ace (State or F	Foreign
	Director		213-54-3182 Usual Residence of Decedent	1 🗆 M 2 🛣 F	62	Yrs.	Indiana Says	1,00,0	Sept 5		1	$\H{ taly}$	
	/land	tor	10a. State 10b. Count	ty	10c. Ci	ity, Town or Lo					10	d. Inside City	
	e Mary	Direc	MD Carro	011		Westm	inster					1 🗌 Yes 2	! [X] No
	a 23a o	Funeral Director	2052 Kimjo Dr	ive			10f. Zip Code 21157			10g. Citizen of USA	What Count	ry?	
36	e filed within 72 hours after death with the Maryland tal Hyglene.  ed other than "natural", or itama 23a or 28a-f ahow event, the Medical Evaninar must be autilied at		11. Marital Status 1  Never Married 2  Marital	arried Armed Fo	2 No	1	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2 🔯 No	n, Mexican, F	n? (Specify Yes or No Puerto Rican, etc.)	Bla	ce - America ck, White, e	tc.	
ő	atural	Completed by	3 Widowed 4 Divorce	ed Year or Da			dent's Usual Occupa				white		
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121	iled within Il Hyglene. other tha	Be C		2	401047	h	airdresse			hairdressing			
yland	uld be filed Mental Hygnarked oth	일	17. Father's Name (First, Middle, Angelo DiGangi						s Name (First, Middle la DiCarl		e)		
Baltimore, Maryland 21215-0036	1 and 2 should be of Health and Ment I Item 27 is marked other traumatic s		Mr. Phillip Bu		e)				or Rural Route Number,			ode)	
imore	permit. Page 1 a Department of H Important: If ite any injury or oti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other	n 3 🗆 Removal from (Specify) entomb	State	cemetery, cren 11anev	sition (Name of natory or other place Valley Mei	m. 18-	Date -4-12	20c. Location Timoniu	m, MD		
Balt	Departs Departs Import any injude.		21. Signature of Funeral Service	Licensee		22	. Name and Addres	s of Facility	aight Fun			hapel	
	20200	Н	23a. Part 1. Enter the disease, of	or complications that	caused the dear				esville, l		_	Approximate	_
P	nysician/	8 3	shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on ea	ach line	DUR	7.0		AMOM	A		Interval Betwe Onset and De	
home	Medical Examiner		resulting in death)	Due to	(or as a conseq	quence of):	.,,		,,,,,	4			
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	e executed cian and ourlai-transit	I= I	that initiated events resulting in death) Last	c. Due to	(or as a conseq	quence of);		0	ADDROVED BY MED	CAL EXAMINER			
200	certificate be inding physici use as the bu	ledic		d				CERTIFICATION	M Marine				
Bo	death le atte ed for		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 🔲 Live	tcome of pregna Birth 2  Fet nant at time of nown	tal death 3 [	Ectopic pregnancy Other (specify)	у			ate of deliver	y Day Yea	эr
О.	s that the		Part II. Other significant condit	ions contributing to d	eath but not re:		1	en in Part I.	23e. Did	tobacco use cont	ribute to the	cause of dea	th? -
rds,	een sig	pete	qua At	The Market	yex	$\alpha$	flere		_ 10	Yes 2 No	3 Prob	ably 4 🗌 Un	iknown
Division of Vital Records,	The law ate has bage 2	Completed by	Armer 1	7 mar 16	ZIW	<del>ق</del> سر				opsy ormed?	Were autop: prior to con death? 1 \( \subseteq \text{Yes} \)	sy findings ava npletion of cau	ulable se of
ital	sician: The certificate rector, pa(	æ	25. Was case referred to medica examiner?	Hospital:			Othe		(Check only one)				(m) (t)
و د	g Phys er this neral di	은 :e:	1 X Yes 24110 27. Manner of Death	28a. Date		28b. Time of	28c. Injury	4	ing Home 5 Resi	how injury occurr	ed 1	LOUGIC	2
o	anding eath. or: Aft the fur	ficat	1 Natural 5 Pend 2 Naccident Inves 3 Suicide 6 Could	tigation JULY	th, Day, Year) 29,201	2 UNK	M 1 🗆	? Yes 2. TXN	SUBJECT	FELL UP	ON EX	ITING	_
Divisi	To the Hospita or Attanding Physician: within 24 hours after death. To the Funaral Director. After this certifics completely filled in by the funeral director, I	al Certificate:		mined 28e. Place	ng, etc. (Specif)		eet, factory, office		28f. Location ( City or To WESTMI	Street and Numb wn, State 2052 NSTER, M	er or Rural P KIMJ D	Route Number, O DRIV	Е
	he Hoap in 24 hou ha Funai ipletely fl	Medical	(Check 2 L Medical	ng Physician: To the b Examiner: On the bas ng Nurse Practitioner	sis of examinatio	on and/or invest	igation, in my opinio	n, death occu	rred at the time, date	and place, and du	e to the caus	se(s) and mann	er stated.
	Verth com		29b. Signature and title of certific	Jule	r M	M	29 License	Solumber 3	18	29d. Date signe	d (Month, D	ay, Year)	
_	(9)		30. Name and address of person	uter.	MO 5	35 J.	Certer	5%	Westm	inster	MO	2115	7
	Stat Registra	e ir	31. Date filed (Month CG, 28	2012	egistrar's Signa	d. Sa	the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple, 2 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William D. Boyle Month 2012 0530 August Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Nursing Center Dundalk Baltimore Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 20, 1930 Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 215-24-5916 1 🖎 M 2 🗆 F **Director** 82 or 28a-f show notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Middle River 1 🗆 Yes 2 🔀 No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 12117 Buttonwood Lane 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural". 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Machinist Beth Steel 12th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ agne 5 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu ber or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 si Department of Health ai Important: If item 27 is any injury or any Scott Boswell/step-son 548 Doefield Court Abingdon MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus 8/28/12 Baltimore MD 4 Donation 5 Other (Specify) 21. Signature 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex mplications that cal 23a. Paul 1. Enter the disease, of complications that shock, or heart failure. List only one cause on ea sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician, CANCER disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Physician/Medical EMIP Box 68760 attending phys the IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 \( \subseteq \text{ Yes} \) 2 \( \subseteq \text{No} \) Month Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown should b Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy prior to completion death? perform Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 X No Other 잍 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 atural 5 Pending work' 2 🗌 No eral Director: A 1 🗌 Yes after death Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a

To the Funeral C

completely filled Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier n du

State

Registrar

Date filed (Month, Day, Year

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 7:58 Рм Melvin Bernard Bellamy Jr. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Fort Washington Prince George's 8. Date of Birth

(Month, Day Yea

Dec. 31 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours Year) 1942 New York Yrs Director 69 578-58-0998 Usual Residence of Decedent 28a-f show 10c. City, Town or Location at 10a. State 10d. Inside City Limits Director ir than "natural", or items 23a or 28a-fs the Medical Examiner must be notified Prince George's MD Oxon Hill 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20745 6504 Livingston Rd within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Marshall Svc. 12th Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Grace Summers Melvin B. Bellamy Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6202 Dimrill Ct. Ft. Washington, MD 20744 Gwena Bellamy/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Riverdale Crematory 8/31/2012 Riverdale, Maryland 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Signature of Funeral Service License 7474 Landover Rd. Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Ardiopulmonning ANCOF disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CONONINA ALKIN DICEJO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Mimotofic Concinoma (0)UN attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? page 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No မ 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) nin 24 hours after death.

the Funeral Director: After thi
npleted filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending ✓ Natural 5 Pending work 2 1 No 1 Yes Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I complex only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 300 8/15/2012 (DC) 681 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Fort Washington, MD 20744

Alfred Burris -11711 Livingston Rd.

Registrar's Signatur

			For State Registrar	State of N	/larylan			nt of H te <i>of D</i>		and M	_	giene Reg. N	_ Z U	12	273	355
	Physicia		1. Decedent's Name (First, Middle Warren	charles	)						2. Date of De Month	ath	ay \	Year 012	3. Time of D	
-	Medic Examin		Warren Charles Baum August 22, 2012  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Deat									J.4J	A			
		Maplewood Park Place						Bet	hesd	a		Montgomery				
	Funeral Director		5. Social Security Number 022-16-9093	6. Sex 7. A 1 💢 M 2 □ F	ge (In yrs. la	ast birthday) Yrs.	If Unde Months	Days	If Unde Hours	Min.	8. Date of Bir (Month, Da Sept • 2	th y, Year)	922	9. Birthpla Countr Ne	ace (State or F y) W York	-oreign
36	within 72 hours after death with the Maryland glefne. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at.	١	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Loc	cation							10	d. Inside City	Limits
		Director	MD Mon	MD Montgomery Bethesda						1[					2 X No	
											10g. Citizen of What Country?					
		Funeral	9707 Old Gero					20814				United Stat				
		Completed by Fu	<ul> <li>11. Marital Status</li> <li>1 ☐ Never Married 2 X Mar</li> <li>3 ☐ Widowed 4 ☐ Divorced</li> </ul>	ried Armed Forces 1 X Yes 2 If Yes, Give	If Yes, Give Year or Dates. W.W. II  Education grade completed)  16a. [		<ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.</li> <li>1 ☐ Yes 2 X No Specify:</li> </ol>				cify Yes or No- Rican, etc.)	Black, Whi				
9	hours natura lical E	lete	15. Decede	nt's Education			L       16a. Decedent's Usual Occupation     (Give kind of work done during most of work     life. DO NOT use retired)				rking		p. Kind of Business Industry			
21215-0036	1 and 2 should be filed of Health and Mental Hy item 27 is marked oth other traumatic event	dwo	(Specify only higher Elementary/Seconday (0-12)	est grade completed)  College (1-4 or						st of worki					•	
121		Be C	47 Fall all bland (First Middle)	5+		Ec	conon	ist					nking			
Maryland		To B	17. Father's Name (First, Middle, 18) William	_	Baum					ner's Name <b>lsie</b>	e (First, Middle,	Maiden	,	dler		
ary			19a. Informant's Name/Relations			19b. Mailir	ng Addres	s (Street a			I Route Numbe	r, City o			ode)	
			Nancy B. Lohm	an / Daughte	er	413 F	Cirst	en S	t.,	Gaith	ersburg	ş, M	D 20	878		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (3	3 ☐ Removal from Stat	e c	Place of Dispo emetery, cren esapeak	natory or	other place			5/2012		Location - C $8e1$ ts $v$	•		
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Gensee A	10038	1770	Name i PP I 33 Gi	nd Addres uner	s of Facil al al	nd Cr Silv	ematior er Spri	se ng.	rvice MD	s 209	10	
	Ph_sician/ Medical Examiner  the pnial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										een			
			Immediate Cause (Final disease or condition		PNEUMONIA										Onset and De	
			resulting in death)		Due to (or as a consequence of):  STROKE											
		Jer	Sequentially list conditions,	b. —	b. — Due to (or as a consequence of):											
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events													
		E	resulting in death) Last Due to (or as a consequence of):													
09,	ate be ohysic the bu	edical	d													
Box 687	ath certifica attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	3c. If yes, outcome of pregnancy								23d. Date	of deliver		
30x	: The law requires that the death cate has been signed by the atten page 2 should be detached for u	Physician/M	23e. Did tobac   PARKINSON   S DESEASE   CERVICAL STENOSIS   Live Birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   23e. Did tobac   23e. Did tobac   24e. Was an autopsy performer							Month			Day Year			
P.O. E		Phys														
٠ <u>.</u>		l by								res 2XXNo 3 Probably 4 Unknown						
rds		etec								24b. Were autopsy findings available						
ecc		Completed by							osy ormed?	prior to completion of cause of death?						
al B	sician: The certificate I rector, pago	Be C	25. Was case referred to medical					26. Pla	ace of De	ath (Check	1 \(\simega\) Yes	2 🗶 1	No 1 L	_ Yes 2	2 LJ No	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	To B	examiner? 1 Yes 2 XNo	Hospital: 1 ☐ Inpa	itient 2 🗆	ER/Outpatier	nt 3 🗆 🛭	DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify)								
			27. Manner of Death 1 X Natural 5 □ Pendi	/A 4 + 1- E	be 29a Place of Injury. At home form street			28c. Injury at work?			28d. Describe how injury occurred					
		Certificate:	3 🔲 Suicide 6 🗀 Could					M 1 Yes 2 No			28f. Location (Street and Number or Rural Route Number,				,	
Divis			4 □ Homicide detern	building, e	building, etc. (Specify)					City or Town, State)					,	
_		Medical	29a. Certifier  (Check only one)  1								ner stated.					
	To th To th comp	<	29b. Signature and title of certifie		-			29c. License number				ate signed (	signed (Month, Day, Year)			
			/ tang 6	Jan 6 Willem ng D55258 AUGUST							T 23	, 2012				
VI			30. Name and address of person GARY G. WILKE	·				. #2	11.	BETHE	SDA, MI	) 2.	0814			
	Sta	te	31. Date filed (Month, Day Year)			ture			- ,		, ,					
	Registra	ar	AUU &	0 CU12	wh	p. 14	ark	1								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death BRANDON 04:23 M MMA Physician/ 200 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 603 N. Potomac St. Baltimore n/a **Funeral** Social Security Number 6, Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (Month, 1 M 2 X F Months Hours Min. Day, Director 85 219-14-0952 Va Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Funeral Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MDn/a X□ Yes 2 □ No 10g, Citizen of What Country? USA ral", or items? Examiner mus 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 XNo 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify. "natural", 3

Widowed 4 □ Divorced Specify : If item 27 is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha 7th Housewife Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virgia Woody Royster Goodes and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains Baltimore Md 21207 Doris Fowlkes/Daughter Walden Ct. 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State CrownsvilleVetCem Aug.30,2012 Crownsville MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD 21. Signature of Fulleral Service Li 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. BREAST Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ξ Pregnant at time of death Month Day Year detached 9 Unknown g Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Yes 3 Probably 4 Unknown page 2 should 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of Jas performed? Yes 2 death? 1 Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral ( 27. Manner of Death

1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti

State

31. Date filed (Month.

rson who completed cause of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C931 9/11/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0305 A.M Delmar Darlene Berry WUS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITA Agnes Baltimore 6. Sex <u>2948e64V9295</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min (Month, Day, Year) ct. 24, 1955 Mary Tand **Director** Oct. 56 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21061 1627 Pleasantville Drive United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. If Yes, Give Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Technician Sprint Telephone Company Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Delmas Berry Margaret House 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Justin Ray Poe / Son Pleasantville Drive, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery Aug. 25, 2012 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal e Fu Service Licensee 22. Name and Address of Facility ROSE FUNERAL HOME, INC. any i Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Seset and Death Priysician/ cel cancer disease or condition resulting in death) ma Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a surrougueries of): Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy the Hospital or Attending Physician: The law requires that the death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Division of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Natural injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a 29c. License number D1858 30. Name nd address of person who completed cause of death (Item 23a) (Type, Print), au 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Berry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST 22. 201<sup>Y</sup>2° 5:40a M MARJORIE G. BOWERS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE STELLA MARIS HOSPICE TIMONIUM ocial Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 217-20-0524 (Month, Day, Year) 3-16-1925 **Director** MARYLAND 1 M 2 XF 87 Yrs Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 🗆 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe Funeral 521 RADNOR AVE. 21212 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 Yes 2 X No Specify: Completed 3

▼ Widowed 4 □ Divorced BLACK the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other to any injury or other traumatic event, the Once. -0-ADMINISTRATIVE ASSISTANT BALTO. PUBLIC SCHOOLS Be Maryland 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) GLADYS JONES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7409 RICKS WAY PIKESVILLE, MARYLAND 21208 BERNARD BOWERS (SON) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 4 Donati 2 🗌 Cremation 3 Removal from State GARRISON FOREST VETERANS 9-30-2012 OWINGS MILLS, MARYLANI ion 5 Other (Specify) Signatur Licensee JONATHAN D. HIBNER. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. 23a. Part shoo Interval Between Immediat ause (Final disease or condition resulting in death) Onset and Death Physician/ LEUKEMIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Year Pregnant at time of death Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 🗆 Yes 2 🗆 No 3 🗀 Probably 4 💢 Unknown Certificate: To Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 201 address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD.

State Registrar 31. Date filed (Month

AUGUST

MARJORI

MD 21093

TIMONIUM.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Year August 27, Helen Crouthame1 9:45 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 845 Seneca Park Road Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months Hours (Month, Day, Year) Director 215-34-5313 1 □ M 2 👿 F 95 Dec. 26, 1916 Maryland Usual Residence of Deced 28a-f shov 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified MD 1 🗌 Yes 2 💢 No Baltimore Middle River 10e. Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? pe Completed by Funeral 23a ?7 is marked other than "natural", or items 23: traumatic event, the Medical Examiner must. 845 Seneca Park Road 21220 United States and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Nurses Aide Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Clarence J. Green Genevive Louise Sevier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a Kenneth Hubbard (Son) 846 Seneca Park Road, Middle River, Maryland 21220 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 🗶 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 8/28/2012 Catonsville, Maryland of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of MD. Inc. Signati 299 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death disease or condition metas tatic brist concer 4 mas Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available page 2 s autopsy prior to completion of cause of death? performed? Hospital or Attending Physician: The this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work of the state of th Accident
Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 3 [ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OU 040850 8/27/2012

DHMH 17 Rev 06-2011

State Registrar JUCINE

31. Date filed (Month, Day Year)

Square Drive

Bulbmir

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OTTAVIANOMD, 9103 Franklin

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012

			For State Registrar	tate of Maryla	and / Depa <i>Cei</i>	artment of I rtificate of L	Health and I Death	Mental Hy	giene Reg. No.	012	27360	
	Physician/ Medical		Decedent's Name (First, Middle, Last)     In			2. Date of De	ath 23 <sup>y</sup>	2012	3. Time of Death 1:44 P M			
8	Examir		4a. Facility Name (if not institution, give street 2738 E. Biddle Street	et and number)  4b. City, Town, o			r Location of Death Baltimore		4c. County of Death			
3-1	Funeral Director		5. Social Security Number 218-10-5734 6. Sex	7. Age (In yr.	s. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	Date of Birth (Month, Day, Year)		9. Birthplace (State or Foreign Country)	
3	/land f show d at	tor	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits	
00	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	MD 10e. Street and Number			10f. Zip Code	Baltimore		10g. Citizer	of What Coun	1 ✓ Yes 2 □ No	
(	ath with ems 23a r must t	unera	2738 E. Biddle Street  11. Marital Status 12. W	/as Decedent Ever in	U.S. 13. \	Was Decedent of H	21213	ecify Yes or No-	14	USA Race - Americ	an Indian	
#57 1036	s after ral", or Exami	è	1 Never Married 2 Married 1	rmed Forces?  Yes 2 No Yes, Give ear or Dates.		f Yes, specify Cuba 1 ☐ Yes 2 ☐	an, Mexican, Puerto	Rican, etc.)		Black, White, e	etc.	
. Cotts	within 72 hours after giene. er than "natural", or , the Medical Exami	Completed	15. Decedent's Education (Specify only highest grade con	mpleted)	(Give	dent's Usual Occup kind of work done o O NOT use retired)	during most of work	king	16b. Kind	of Business Inc	iustry	
1212		Be Co	Elementary/Seconday (0-12)  17. Father's Name (First, Middle, Last)	ollege (1-4 or 5+)	<b>I</b>	MESTIC		(5)		Domest	tic	
yland	d be file Mental H arked o	일	Vanc			18. Mother's Nan			ie Wilson			
ore, Mar	ge 1 and 2 should be filed within 72 hour nt of Health and Mental Hygiene.  If item 27 is marked other than "natur or other traumatic event, the Medical		19a. Informant's Name/Relationship (Type, Pr Pauline Phyllis Brooks / Daugh			ng Address (Street steneagle Rd,			r, City or Tov	vn, State, Zip C	lode)	
Ifene A Baltimore, Maryland	permit. Page 1 and 2 st Department of Health as Important: If item 27 is any injury or other trai		20a. Method of Disposition  1. ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State		esition (Name of matory or other place e Cemet		Date 9/2012		ion - City or To		
Balti	permit. F Departm Importa any inju		21. Signature of Funeral Service Licensee	1553		2. Name and Addre		rices, 4905 Y	ork Roa	d, Baltimor	re, MD 21212	
1	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
			Immediate Cause (Final disease or condition resulting in death)  a. COYONGY CAYELY Disease  Due to (or as a consequence of):									
	Examiner	ner	Sequentially list conditions, if any, leading to immediate Due to for as a consequence of:									
35	executed an and rial-transit	xami	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.  Due to (or as a consequence of):									
5092	pe pici	edical Examiner	d									
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Me	FFEMALE:   23c. If yes, outcome of pregnancy   23d. Date of del								ery Day Year	
P.O. B	t the dea by the a	Physic	1 Yes 2 No 4 9 Unknown 9									
S, P.	uires tha n signed ald be de	ed by	Part II. Other significant conditions contribu		de. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
Division of Vital Records,	law requ	mplet	24a. Was an autopsy prior to co								osy findings available mpletion of cause of	
al Re	ian: The rtificate ctor, pag	Be Co	25. Was case referred to medical examiner?	•		26. Pl	ace of Death (Chec	1 Tes	2 No	1 Yes	2  No	
of Vit	Physic rthis ce aral direc	은	1								1	
ion	tending leath. tor: Afte the fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation 3 Suicide 6 Could not be									
Divis	tal or At is after c al Direct ed in by		4 Homicide determined determined building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rura City or Town, State)									
	e Hospi 124 hou e Funer e Funer	Medical	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	To the within 2 To the comple	_	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month									
	À		30. Name and address of person who comple	ted cause of death (It	1 O tem 23a) (Type, F	Durland\	2827	A 14:	0	47/10		
	Sta	to.	31 Date filed (Month, Day, Year)	32. Registrar's Sig		. Paca	a St.	Balt	more	mn	21201	
	Registr		AUG 28 2012	N. B. A	arra							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Canadaamela 00:06 M ugust Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Chesapente Medical Center Harford 7. Age (In vrs. last birthday) If Under 24 Hrs. 1 Year Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Day, Year) 2.70.5939 Director 1 🗆 M 2 🕱 F MD 10/11 1957 'natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Harford Harford Count 1 Yes 2 No 10e. Street and Number 10g, Citizen of What Country? Funeral 21015 USA Cedar thill 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married If Yes, Give Year or Dates. Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4 or 5+) Cemeten 12th grade Year tlemarketina is marked other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moses Canada Garnetta 150020 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) anada, mportant; If item 27 any injury or other tra vette lanada (Sister Cedar Hill Court Harford County MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kinn Park Elmetens 20a. Method of Disposition 20c. Location City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/29/2012 Windsor Milli Signature of Funeral Service Licenses 22. Name and Address of Facility Vaughor C. Greene Funeral Services vaud 8723 Liberty Road Randallstown MD 21133 23a. Part 1. Ent / the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause Final Onsetland Death Physician/ rancieas Metastatic NKNOW disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Other (specify) Month Dav Year Pregnant at time of death 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No ☐ Yes 2 No completely filled in by the funeral director, Be ( 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To npatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pendina work Accident Investigation 1 Yes 2 No within 24 hours after deat To the Funeral Director: 6 
Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature a Name a and address of person who completed cause of death (Item 23a) (Type, Print) aslas filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar

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32. Registrar's Signature

12-00065 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2ADate of Death 3. Time of Death 23 2016 **Physician** /Medical 4a. Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 XXM 2 □ F Oct 7, 1980 31 Director 218-15-6190 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2XX No Director MD Pasadena Anne Arundel 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 189 Dunlap Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes YY No Specify: Specify: White à 3 ☐ Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Constuction Carpenter 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wanda Golden Walter Clubb ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 189 Dunlap Rd., Pasadena, MD 21122 Walter Clubb Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug 24, 2012 Baltimore, MD Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22 Name and Address of Facility, P.A. K. Gregory M01148 426 Crain Hwy.S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rolce disease or condition resulting in death) /Medical Examiner Nervous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequence of the case Examiner The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 - Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe certificate has page 2 No Yes 1 Tyes or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 □ No 2 - ER/Outpatient 3 - DOA Yes Inpatient မ After this Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 27 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Tes 2 🗌 No Accident death after death the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 24 and manner stated. 29b. Signature and title of certific ES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Kornbe 31. Date filed (Mo State Registrar

DHMH 17 Rev 1/2001

COOK, ARTHUR J

			Please Type	or Print in I							egible.	
			for State Registrar	Oriviaryian		tificate of		and Me			012	27363
t	Physicia	n/	Decedent's Name (First, Middle, Last)				-		. Date of Deat	:h	<del>-</del>	3. Time of Death
	Medic	al	Arthur J. Cook, Sr.  4a. Facility Name (if not institution, give street and i	a comp fo ord					dgust	<del></del>		4:50 A M
	Examin	er	Greater Baltimore M		Cente	4b. City, Town,	r Location of Towsor			Bal	unty of Death timore	9
	Funeral		5. Social Security Number 6. Sex $218-14-9356$ 1 $\cancel{X}_{M}$ 2 $\square$	7. Age (In yrs. In	ast birthday)	If Under 1 Year Months Days		24 Hrs. 8. Min.	. Date of Birth (Month, Day,		g. Birthp Count	lace (State or Foreign
	Director ≥		Usual Residence of Decedent	F 87	Yrs.			J	Jan. 31	,1925	5	Maryland
	ryland -f sho ied at	Director	10a. State 10b. County	i	y, Town or Loc	ation					11	Od. Inside City Limits
	the Ma or 28a e notif	Dire	MD Baltimore  10e. Street and Number	Tow	son_	10f. Zip Code				10g. Citizer	of What Coun	1 ☐ Yes 2 ▼ No try?
	n with ris 23a nust b	Funeral	4 Waterway Court #2A			21286				USA		
10	r death or item niner n	by Fur	Armed	ecedent Ever in U.S Forces?		as Decedent of Yes, specify Cub					Race - America Black, White, e	
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at		If Yes,	es 2  No Give Dates.	1	☐ Yes 2 🛣N	o Specify:			Spe	ecify: whi	te
15-0	72 hou 1 "natu ledica	Completed	15. Decedent's Education (Specify only highest grade complet	ed)	(Give A	ent's Usual Occu	during most	of working			of Business/Inc	*
212	iled within 72 Il Hygiene. I other than '		Elementary/Secondary (0-12) College 12	e (1-4 or 5+)		NOT use retired Lieute					lmore C: ce Depai	
pu	e filed ital Hyg ed oth event,	To Be	17. Father's Name (First, Middle, Last)				18. Mother		irst, Middle, N	faiden Surr	name)	
Maryland	should be fill and Mental is marked ( raumatic eve	_	Arthur Warren Cook  19a. Informant's Name/Relationship (Type, Print)		10b Mailin	g Address (Stree		Broa		City or Toy	un Stata Zin C	(ada)
	d 2 sho alth an n 27 is I er traui		Gloria M. Cook	/ wife	I	erway Co				-		ode)
ore	ge 1 and t of Heal if item 2 or other		20a. Method of Disposition 1   Burial 2   Cremation 3   Removal fr	om State	emetery, crem	sition (Name of atory or other pla		Date			ion - City or To	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation Other (Specify)  21. Signature of Full rall Service Livensee	Dula		Ley Men Ga			2012	Timor	nium, M	ork Road
Ba	permi Depar Impor any ir		1 the Villey			ck Towso	,		Home, I	nc.		, MD 21204
Š	Medical Examiner	i.	Sequentially list conditions.	to (or as a consequ	ellar uence of): rtent	hemor			espiratory arre	st,		Approximate Interval Between Onset and Death
09,	ate be executed bhysician and the burial-transit	edical Examiner	if any, leading to immediate Due cause. Enter Underlying Cause (Disease or injury that initiated events c.	to (or a de insequito (or as a consequi								
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian.	by Physician/Medical	in the past 12 months?	outcome of pregna ve Birth 2  Feta regnant at time of c nknown	aldeath 3 🗆	Ectopic pregnal Other (specify)	псу			23d	. Date of delive Month	ory Day Year
ls, P.O.	requires that the de been signed by the s should be detached	ed by P	Part II. Other significant conditions contributing t	o death but not res	ulting in the u	nderlying cause g	given in Part I.					e cause of death?
Division of Vital Records,	sician: The law req s certificate has bee lirector, page 2 sho	Completed							24a. Was ar autops perforr 1 \( \subsection \text{Yes} \)	sy		sy findings available npletion of cause of
tal	Physician: The lav r this certificate has eral director, page 2	Be	25. Was case referred to medical examiner?	1/			Place of Death	n (Check on				
Ž <	Physic r this c eral dir	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence  27. Manner of Death  28a. Date of injury  28b. Time of  28c. Injury at  28d. Describe how injury										
ono	ending eath. or: Afte he fun	27. Manner of Death   Natural   2   Accident   3   Suicide   4   Homicide   28a. Date of Injury - At home, farm, street, factory, office   28f. Location (Stree City or Town, Street)   29a. Certifier   1   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause only one)   3   Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause only one)   29b. Signature and title of certifier   29c. License number   29d.								,,		
ivisi	or Atter after de Directo	Certi	4 Homicide determined 28e. Pla	ace of Injury - At ho ilding, etc. <i>(Specify</i>		et, factory, office		28f	Location (Str City or Town		ımber or Rural	Route Number,
Ω	ospita hours uneral	Medical	29a. Certifier 1 Certifying Physician: To th	e best of my knowl	ledge, death o	ccurred at the tir	ne, date and p	olace, and o	due to the cau	ise(s) and n	nanner as state	d.
	thin 24 thin 24 the Fi	Med	(Check 2 ☐ Medical Examiner: On the only one) 3 ☐ Certifying Nurse Practitio  29b. Signature and title of certifier			death occurred a	the time, date		and due to the	e cause(s) a	nd manner as s	tated.
	<b>7</b> ₩ <b>6</b> 8		29b. Signature and title of certifier	000	MD	29c, Licen	se number	220	2	9d. Date 61	gned (Manth, E	ay, Year)
	5X1		30. Name and address of person who completed of	ause of death (Item	23a) (Type, P	int) N. Pa.	11/100	Sint	2550	Town	on Mi	7 2/3/4
	Stat		31. Date filed (Month, Day, Year) AUG 2 8 2012 32	egistrar's Signat	ture	exted	THON	Juli		7 0003	on rei	/ - 4 - 6 /
	Registra	ir i	HUQ & 0 2012	much .	14. 190	*****						

DHMH 17 Rev 06-2011

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 10. 20 PM 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lorien Nursing Home Howard Columbia If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☐ M 2 ☐ F Yrs. Director 214.11.9761 90 June 14, 1922North Korea Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Ellicott City 10d. Inside City Limits 10a. ir than "natural", or items 23a or 28a-f show Howard 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3025 Seneca Chief Trail 21042 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 ☐ No Specify <u>6</u> Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, In Manany enter Elementary/Secondary (0-12) College (1-4or 5+) Liquor Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jin Ho Cho Joo Ok Cha ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Soung OK YOO- Daughter 3025 Seneca Cheif Trail. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crestlawn Memorial 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/27/2012 Marriottsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MOIDSU Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045
nter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **'hysician** conic Quimmar. Obstructive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to minimize that cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 →Yes 2 No 3 Probably 4 Unknown should ours after death.

eral Director: After this certificate has been ifiled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 29c. License number 7382 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLOKOLIC 21117 .0.304 525 conizuo

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month Dev) Year)

State Registrar

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#4a, perPHYS#10e, perFH, G931, 9/4/2012, ws

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 22, 2012 R. Anne Connery 9:23 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <del>408</del> Russell Avenue, #402 Gaithersburg Montgomery Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 217-42-0666 Hours Director 1 □ M 2 🗓 F 86 September 30, 1925 North Carolina Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Russell Avenue, #402 20877 United States within 72 hours after death 11. Marital Status . Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 X Yes 2 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Korea Specify: White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+)
5+ should be filed within and Mental Hygiene. Registered Nurse Nursing 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph William White Edna Vines Bass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sh tment of Health a tant: If item 27 is Martha Connery Britt /Daughter 6675 Millbridge Cv, Memphis, Tennessee 38120 item 2 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ott 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) August 26, 2012 Montgomery Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral ervige Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. Mise ettelan M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Years Death Pnysician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Coronary Artery Disease Years Sequentially list conditions, if any leading to immediate Examine Directo (or as a consequence of cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-tran the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) \_\_\_ Month Pregnant at time of death Day Year 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Renal Failure, End Stage Type II Diabetes 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Anemia 24a. Was an After this certificate has autopsy performed I ☐ Yes 2 🛛 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 🎘 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D68078 August 23, 2012 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Susan Therriault, M.D. 201 Russell Avenue, Gaithersburg, Maryland 20877 31. Date filed (Month, Day, 32. Registrar's Sig ature State **AUG 28** Registrar

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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other treumatic event, the Marcel Exceller and ust be notified at once.	<b>Funeral Director</b>	MD E	Baltimore		**			Parkvi	ille			"	1 ☐ Yes 2,	
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- 1	Physici Medi			M. Demb	eck				2. Date of Do Month Augus		2012	3. Time of Death 9:00p M
- 4	Exami		4a. Facility Name (if not institution,		,		4b. City, Town, o		f Death	4c. County		
	<i>,</i>		Stella Mari  5. Social Security Number			at hinth day	TOWS		M Him I a Data at B		ltimo	
	Funeral Director		220-01-3272  Usual Residence of Decedent	1 M 2 🔏	. Age (In yrs. Ia	Yrs.	Months Days	Hours	Min. (Month, D.	20, 1918	Country	ace (State or Foreign y) Cennesse
	aryland ka-f show ified at	ector	10a. State 10b. County	imore	10c. City	, Town or Loc Ros	edale				100	d. Inside City Limits 1 ☐ Yes 2 🛣 No
	rith the M 23a or 28 st be not	Funeral Director	10e. Street and Number 5028 Bri	ght Leaf	Cour	+	10f. Zip Code 2123	7		10g. Citizen of V	Vhat Countr	
р.ш.	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Merital Hygiene. It may be seen that "hygiene item 23 or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 XMarrie 3 Widowed 4 Divorced	12. Was Deced	ent Ever in U.S es? 2 <b>X</b> No	. 13. V	Vas Decedent of H	ispanic Origi an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14. Race	e - Americar k, White, et Whi	c.
9:00 p.m.	within 72 hou giene. er than "natu ; the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th	's Education t grade completed) College (1-4	or 5+)	(Give k	ent's Usual Occup ind of work done of NOT use retired) emaker	durina most	of working	16b. Kind of Bu		istry
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20	should and Me is mar		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street	and Number	or Rural Route Number	er, City or Town, S	tate, Zip Co	de)
	and 2 s Health tem 27		Andrew F. D	embeck/h				t Lea	af Court	I .		
	Page nent o ant: If		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Sp.		toto Cé	emetery, crem	sition (Name of latory or other place idge Ce	neter	Date 8/30/1	20c. Location - 2 Balti		
AUGUST	permit. Page Department Important: I any injury o		21. Signative of Funeral Service Lic	Roll	us		Connell	y Fur	300 Mace neral Hom	e of Es		
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A	Medical Examiner		resulting in death)	d. —	as a conseque							
٩	ed set	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to (or	as a conseque	ence of):						
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Ж.	ficate g phys as the	101	<u></u>	d								
DEMBECK Boy 687	atter for u	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛣 No 9 □ Unknown		rth 2 🗀 Fetal int at time of de	death 3 🗌	Ectopic pregnand Other (specify)	:y		23d. Dat Mor	e of delivery oth D	/ ay Year
VIOLA	res that t signed by	d by P	Part II. Other significant condition	s contributing to dea	th but not resu	Ilting in the ur	nderlying cause giv	en in Part I.		obacco use contri Yes 2 \( \square\) No		
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0	in: The ificate or, pag		25. Was case referred to medical				26 PI	ace of Death	1 Ses	ormed? d	eath?	□ No
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V Division of Vital Bosonia	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At hon, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Location ( City or Tov	Street and Number vn, State)	r or Rural R	oute Number,
Ī	ne Hospit in 24 hour ne Funera pletely filli	Medical	(Check 2 L Medical Ex	aminer: On the basis	of examination	and/or investig	pation, in my opinio	n, death occ	place, and due to the courred at the time, date at and place, and due to	and place and due	to the cause	e(s) and manner stated
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	Sta	te.	JACKIE JONES, C		DULANI istrar's Signatu	EY VAL	LEY RD.	TIMON	IUM, MD 21	093		·
	Registr	ar	AUG & O ZUIZ	Leneur	p. 1900	West						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 2012 Nancy S. Donaldson 5:07  $\mathbf{P}^{\mathsf{M}}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 578-42-9514 Director 1 🗆 M 2 ី F 02/11/8 81 May 30, 1931 Maryland Usual Residence of Decedent ir than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Clarksburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23620 General Store Drive 20871 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Owner Travel Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donaldson Joseph Schlosser Ruth Derrenbacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Leslie Donaldson / Daughter 23620 General Store Drive, Clarksburg, Maryland 20871 Important: If item any Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 g Date Department of August 29, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) Entombment Gate of Heaven Cemetery Silver Spring, Maryland 2012 21. Signature of Funeral Service Ucensee Rôbert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 M01305 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Respirator disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Shock otic Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examin I or Attending Physician: The lew requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Gram bacterenia nea that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **1**00 1 🗌 Yes မှ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatupe ndrtitle of certifie mych 74336 address of person who completed cause of death (Item 23a) (Type, Print) Rockville abinosa 9901 Medical Center Drive 31. Date filed (Month, Day, Year) 32. Registrar's State 8 Registrar

1707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh e930 8-28-12 yt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Fort Jr. 08 Medical 4a. Facility Name (if not institution, give street and number) 2712 Parkwood Ave Examiner 4b. City, Town, or Location of Death Baltimore 4c. County of Death 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 226-20-6916 Director 1 🕅 M 2 🗆 F 87 03 23 25 NC permit. Paga 1 and 2 should be filad within 72 hours aftar death with the Maryland Dapartmant of Haaith and Mentel Hygiena. Importent: If Item 27 is marked other than "naturel", or itams 22e ---- ery liniuy or other traumetic avent; the Maryland once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2712 Parkwood Ave 21217 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Š 1X☐ Yes 2☐ No If Yes, Give 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced Specify: Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Beth Steel Elementary/Secondary (0-12) College (1-4 or 5+) 7th grade Crain Operator na Sparrows Point Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည William Fort Sr. Clora Walls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18144 Wayne Morris Forte-Son 474 Philadelphia, West Manheim Street, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 8/30/201 2 Owings Mills, Md 21. Signate 22. Name and Address of Facility
March F/h West erof Funeral Service Ligensee 4300 Wabash Ave. Baltimore, 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition 1012 resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). To the Hospitel or Attanding Physicien: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗵 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🐼 No 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medica 26. Place of Death (Check only one) 1 ☐ Yes 2 XXIIIo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural iniury 5 Pending Work? 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gettifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Gettifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 76 2 29d. Date signed (Month, Day, Year) 18-23-12 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharpn

DHMH 17 Rev 06-2011

State Registrar 010

31. Date filed (Month, Day, Yea AUG 2 8 201

Frederi

- Suite 18

Rd

32. Registrar's Signature

Baltino

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			State Registrar					tificat						10.20	12	2737	12
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200	Funeral Director		5. Social Security Nur 578-72-2	2336	5. Sex 1  M 2  X F	7. Age (In yrs. 59	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D Nov 1	ay, Year)	952	9. Birth Cour DC	place (State or Fore ntry)	ign
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	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Numb	per		2		10f. Zip	Code 0602				_	Citizen of N			
036	er dea or ite niner	þ	11. Marital Status  1  Never Marries 3  Widowed 4	d 2 <b>X</b> Marrie	12. Was Dece	edent Ever in U proes? 2 <b>X</b> No ve ates.	li li	Vas Deced	lent of His	spanic Oriç n, Mexican	, Puerto	cify Yes or No Rican, etc.)		14. Rac	e - Americ k, White,	can Indian, etc.	
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d 21	filed within all Hygiene.	Be	10th 17. Father's Name (Fir	rst, Middle, La	st)		Teac	ner		18. Mothe	er's Name	e (First, Middle		Surname			
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e, Mai	1 and 2 shoul of Health and item 27 is m other traum:		19a. Informant's Nam  Bobby L	Fonv			3062	End	icot	nd Numbe	er or Rura E <b>V</b>	Route Numb Taldor		n Town, S Md		602 	
Baltimore, Maryland	Page 1 and 3 ment of Healt tant: If item 2 iury or other		20a. Method of Dispos 1 X Burial 2 4 Donation 5	Cremation 3	□ Removal from	State   i	Place of Dispose cemetery, crem 2 V L TOPE	natory or o	ne of ther place MCK			Date D   (Z				own, State	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Fure	ral Service Lic	nsee SCC	257						Laugh] ashind				Home	
Ö	Physician/ Medical Examiner		23a. Part 1. Enter the shock, or hear shock, or hear shock and in mediate Cause (Findisease or condition resulting in death)		_a Sta	_	h. Do not ente						rrest,	dele		Approximate Interval Between Onset and Death	
	ecuted and I-transit	Examiner	f any, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Las	lediate ing ury	c. H	(or as a consector as	quence of): 600	mi	u o	us.t		on (	20				
09289	cate be ex physician the buria	edical			d	hion	ic 1	rid	nec	}	lis	eer			_		
Box	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the becompletely filled in by the funeral director, page 2.		IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 ☐ Yes 2 🔀 9 ☐ Unknown	onths?		Birth 2 Fet nant at time of	al death 3	Ectopic p		/				23d. Dat Mo	e of deliventh	ery Day Year	
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of Vi	ng Physical this of the neral directions of the direction of the direction	te: To	27. Manner of Death	No	1 28a. Date	_	ER/Outpatient 28b. Time of injury		Other 3c. Injury work?	<u>4 ∟ Nu</u> at		me 5 Resi				)	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certificate:	2 Accident	5 Pending Investigat 6 Could no determine	t be 28e. Place		ome, farm, stre	M et, factory,	1 🗆 ነ	/es 2□		28f. Location ( City or Tox			r or Rural	Route Number,	
_	the Hospita nin 24 hours the Funera npletely fille	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical Exa	hysician: To the b miner: On the bas urse Practitioner	is of examination	n and/or investi	gation, in n	opinior	. death oc	curred at	the time, date a	and place	e, and due	to the car	use(s) and manner st	atec
	with to con		29b. Signature and title	e of certifier	Kam	CH	P	29c.	License	number	80		29d. Da	ate signed	(Month, I	Jay, Year)	
l	V		30. Name and address	of person wh	o completed caus	e of death (Iten	n 23a) (Type, Pr	750	3 5	urra	att	Rd C	lin	ton	Md :	20735	
	Stat		31. Date filed (Month, I	Day, Year)		egistrar's Signa	ture	, ,								<u> </u>	

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ 2012 Medical Eacility Name (if not institution, give street and number) 4c. County of Death **Examiner Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months (MO5/24/195)1 CONTEN York 054-44-2950 61 **Director** 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 No Watervliet NV Albany 0 10e. Street and Number 10f. Zip Code items 23a or ner must be n 10g. Citizen of What Country? Funeral 12189 USA 101 6th Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1X Yes Manue Corps
If Yes, Give 11. Marital Status 14. Race - American Indian Examiner Black, White, etc. 5 by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Puerto Rican "natural", Completed 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+ Broker Real Estate 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mildred Valdes Luis Figueroa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 6th Avenue, Watervliet, NY 12189 Maria Mendez / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Chesapeake Crematory 8/28/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility any Dorota Marshall ) Develo Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Ph sician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No ģ Year Day Pregnant at time of death detached the 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate has 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital Other: 2 💢 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

10 NORTH GREENE STREET BALT:MORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012

		1- For State Registrar	Certifica	te of Death	, ,	eg. No.	2 2131		
Physic Medical Exam		Decedent's Name (First, Middle,Last)			2. Date of Dea	ith	3. Time of Death		
wedicai Exam	inei	TYRONE M. FREDERICK  4a. Facility Name (if not institution, give street and	oumbor)	I do Oit Town of the Control	August 18		0300 hrs		
		Mercy Hospital	number)	4b. City, Town, or Location of Baltimore	of Death	4c. County of Death N/A	1		
Funeral		Social Security Number	7. Age (In yrs. last birtho		er 24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bin	thplace (State or		
Director		217-52-6341 1XXM 2_F	62	Yrs. Months Days Hours	1.00	Foreig			
		Usual Residence of Decedent					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
w any		10a. State 10b. County	10c. City, Town or	r Location			10d. Inside City Limits		
Maryland 28a-f show 1 at once.	ই	MD. N/A	BALTIM				1 X Yes 2 No		
e Mary or 28a ied at	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Cour	ntry?		
with the Maryland ms 23a or 28a-f sho be notified at once.	a D	TOLI INITIDION DIS	and and Employed	21217		USA			
death w or items	Funeral	1 Never Married 2 X Married Armed	Forces?	<ol> <li>Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,</li> </ol>		14. Race - Ameri White, etc.	can Indian, Black,		
e 2		1 Yes 3 Widowed 4 Divorced If Yes, Give Yo		1 Yes 2 No specify:		Specify: BLA	CK		
ours a satura	d by	15. Decedent's Education (Specify only highest gr		ecedent's Usual Occupation (Give I		16b. Kind of Business/I			
16 n 72 h	Completed	Elementary/Secondary (0-12) College	(1-4 or 5+)	ring most of working life. DO NOT	use retired)				
003 within giene.	J W	-11 17. Father's Name (First, Middle, Last)	0- S	UPERVISOR		CITY CLEA	NING		
15- filed al Hyg	Be C				s Name (First, Middle, I				
21215-0036 21215-0036 ould be filed within 7 Mental Hygiene. marked other than ic event, the Medica	To B	WILLIE GOODMAN  19a. Informant's Name/Relationship (Type, Print )	19b.	Mailing Address (Street and Num	AULINE CLAE berorRuralRoute Nun		Zin Code)		
TOTE, MD 21215-0036 signs 1 and 2 should be filed within 72 hours at the off-Beath and Mental Hygiene. It If item 27 is marked other than "natural other traumatic event, the Medical Examin	٦	PEARL FREDERICK (WIFE)	VI.	621 APPLETON ST					
MOFE, Neges I and nent of Health ant: If item		20a. Method of Disposition  1 Burial 2 XC/emation 3 Removal	20b. Place of I	Disposition (Name of cemetery,	Date	20c. Location - City or			
Pages		4 Donation 5 Other Specify:		CREMATORY	8-24-2012				
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr		21. Su calue 11 uneral Survice Luens 10/1/1	TIAN D. HIBN	R Name and Address of Facility	PHILLIPS FU	NERAL HOME,	P.A.		
	N 0	23a. Pa Vi. Enter the disease, or complications that	FUR	1721-27 N. MONRO	DE ST. BALT	IMORE, MARY			
Physician /Medical	ar sa	failure. List only one cause on each line. Hy	poxic- Ische	mic Encephalopa	rdiac or respiratory arrothy following	est, shock, or heart	Approximate Interval Between Onset and		
Examiner			enous Sedati	on			Death		
		Sequentially list conditions, b							
	Examiner	if any, leading to immediate Due to (or as cause. Enter Underlying Cause	a consequence of):						
=	xam	(Disease or injury that initiated events resulting in death) Last	a consequence of):				- xr -		
ecuted and trans		d							
(ecords, P.O. Box 68760, he law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial - trans	Medical		23a,27,28a-f	,per me,g931 9-	10-12 sm				
8760, itificate be ng physic as the bur		23b. Was decedent pregnant in the	outcome of pregnancy birth 2	Fetal death 3 Ectopic	pregnancy	23d. Date of delivery  Month Da	ay Year		
Box 687 e death certification at the attending of the astending of the set of	icia	past 12 months?	nant at time of death 5	Other (Specify)	p. og. id. io,	Nona B	ay real		
BO) he death y the att hed for	Physician/	9 0118							
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ords, P.C w requires that us been signed to should be deta	Completed				24a, Was a		ppsy findings available		
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of Vital Records, ng Physician: The law require this certificate has been simeral director, page 2 should be		25. Was case referred to medical		00.00	1 Yes 2	No 1 ✓ Yes	2 No		
Vital ysician his cert directo	Be	examiner?	Inpatient 2 FR/Outp	26. Place of Death (Catient 3 DOA Other	Nursing Home 5	Residence 6 Other:			
ting Phy After th	P.	27. Manner of Death 28a. Date	of Injury 28b. Tim	e of Injury 28c. Injury at Work?		ow injury occurred			
<b>-</b> 4 - 2	譩	Natural 5 Pending	n, Day, Year) -15-12   fd 0	9:20 am	v∘ Diagnos	stic Procedu	ıre		
Division tal or Attendi rs after death. al Director: A	<u></u>		e of Injury - At home, farm	, street, factory, office building, etc.	28f. Location (S	treet and Number or Rura	al Route Number, City		
Spital tours a filled filled	Certification:		Oddid Not be						
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only one) 2 Medical Examiner: On the basis	st of my knowledge, death	e(s) and manner as stated	1.				
To the within To the comple	Medical	29b. Signature and title of certifier	stated.	29c. License number	urred at the time, date a				
		01.12.10		O.C.M.E.		29d. Date signed (Mont	h, Day, Year)		
	ŀ	30. Name and address of person who completed cause	ce of death (Item 23a)	J.J.IVI.L.		August 22, 2012			
			,	W. Baltimore Street, Baltin	nore, MD 21223				
			distrar's Signature						
Regist	_	und a a chir	we I	text!					
DHMH 17 Rev 1/20	01	OCMÉ	ORIG	INAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Allen Joseph William Grammer AWG 25<sup>8y</sup> 20<sup>4</sup>1°2 7:00A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 220-50-0291 1 M 2 🗆 F 05/29/1948 64 MD Usual Residence of Decedent , or items 23a or 28a-f show aminer must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Carroll 1 X Yes 2 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1319 Tannery Hill Road 21157 United States "natural", or iterr ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Narried Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oliver Clinton Grammer Edna Alberta Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Grammer-wife 1319 Tannery Hill Rd., Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 8/28/12 Providence Cem. Gamber 21. Signatur (Fiftheral ervice Licensee 22. Name and Address of FacilityFletcher Funeral & Cremation 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph<sub>sician</sub> disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Morbiel Cause (Disease or injury that initiated events resulting in death) Last inding physician and use as the burial-trans Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Is 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 LNO Yes 2 N Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical æ 26. Place of Death (Check only one) Other 1 Yes 2 140 읻 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Dother (Spec funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ( hit 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accider☐ Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR - Raman B - Kaneng 349 Malcalm 21150 Westrynsky delive 31. Date filed (Month, Day, Year) β2. Registrar's Signature State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jimmie Lee Gilliard, Sr. O'A 8:40 PM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death BALTIMORE CI HOS PITAL BALTI MORE MD GOOD SAMARITAN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 248-60-0340 **Director** 1 **X** M 2 □ F 73 07/28/1939 SC Usual Residence of Deceden 28a-f show Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD **Baltimore** 1 X Yes 2 No 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1671 Northbourne Rd. 21239 USA and Mental Hygiene. Is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ρ 1 Never Married 2 Married 1 Yes 2 No Specify If Yes Give 3 Widowed 4 Divorced Specify. Black Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operator Carr Lowrey Glass Co. Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nebe Brooks Mary Levine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Gilliard / Wife Department of Health a Important: If item 27 Is any injury or other tra 1671 Northbourne Rd., Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State matory or other place) 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 8/29/2012 Pikesville, MD 4 Donation 5 Other (Specify) Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 MU/55 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CARDIDGENIC SHOCK Medical resulting in death) Examiner ARREST, CARDIOMY UPATHY TACH/VFIB if any, leading to immediate cause. Enter Underlying Examiner CARDIAC Cause (Disease or injury that initiated events resulting in death) Last AMYLOIDOSIS as the burial-tran Due to (or as a consequence of Physician/Medical AMYLOIDOSIS AMBDA Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CABG, HYPERTENSION, DYSLIPIDEMY 1 Yes 2 No 3 Probably 4 Unknown ON HD, ANEMIA 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law prior to completion of cause of death?

1 Yes 2 No autopsy perform certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗶 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify, 1 X Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 24 hours after death. Funeral Director; After 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide determined Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur MD completed cause of death (Item 23a) (Type, Print) PANA RAY BWD. EDMUND 5601 LOCH RAVEN

State Registrar

AMEN	ID	#21, PER FD, 25, PER ME	G930 8/ Of Marylan	<b>Black Ir</b> 24/12 d / Depa	i <b>delible</b> TRT artment :	ink. E of Hea	<b>=nsure A</b> olth and M	III Copie Iental Hy	s Ar	e Legible -	Э.
		For State Registrar  1. Decedent's Name (First, Middle, Last)			tificate				Reg. N	2011	2 27377
Physician Medica	al	Dolores M. Gorsch						2. Date of De Month	+ 7	ay 2012	2 324 PM
Examine	er	4a. Facility Name (If not institution, give street and nu Upper Chesapeake Med		enter			ation of Death			c. County of De Harfor	
Funeral Director		5. Social Security Number  220-20-9260  Usual Residence of Decedent	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months D		Under 24 Hrs. Durs Min.	8. Date of Bir (Month, Date 4 / 5 / 1	ay, Year)	C	irthplace (State or Foreign ountry) cyland
7CD; e Maryland r 28a-f sho notified at	ector	10a. State 10b. County  Iaryland Harford		rdeen					-	•	10d. Inside City Limits 1₺ Yes 2 □ No
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215-0036  72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at	by	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced  12. Was Dec Armed Find The Status  12. Was Dec Armed Find The Status  13. Was Dec Armed Find The Status  14. Was Dec Armed Find The Status  15. Was Dec Armed Find The Status  16. Was Dec Armed Find The Status  17. Was Dec Armed Find The Status  18. Was Dec Armed Find The Status  19. Was Dec Armed F		11	Vas Decedent Yes, specify	Cuban, Me	ic Origin? (Specexican, Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify Wh	ite, etc.
H, Dolones S/Maryland 21215-0036 2 should be filed within 72 hours after than and Mental hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	E S S O O D Contentary (0-12) Contege (1-4 or 5+)										s/Industry
Maryland 212  Should be filed within the and Mental Hygiene.  27 is marked other the traumatic event, the I	To Be	17. Father's Name (First, Middle, Last) Unknown				18.	Mother's Name				
ore, Maryl 1 and 2 should of Health and Mitem 27 is mar other traumati		19a. Informant's Name/Relationship (Type, Print)  John Gorsch, Sr./Hus  20a. Method of Disposition		527	Parke	St,	Abero			7 Town, State, 2 21001	(ip Code)
Page 1		1 X Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Har		atory or other Mem.	<sup>r place)</sup> Gdns	.8/16/	2012	Abe	ocation - City o	
Balt permit. Depart Import any inji		21. Signature of Funeral Service Licensee  KIRSTEN AMY UNGLESB	EE (PER	$DVR$ ) $\frac{27}{3}$	arrin 33 S.	g-Ca Par	rgo Fu ke St,	neral Aber	Ho dee	me, P. n, MD	A 21001
be e buri	dical Examiner	Sequentially list conditions, if any heading to find details cause. Enter Underlying Cause (Disease or injury that initiated events c.	or as a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a consequence or a co	ence of):	v e	140	RTIFICATION APP	1/-9	iln 17	AMINER	Approximate Interval Between Onset and Death United States
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of Vital Records,  Physician: The law requires  ribis certificate has been signal director, page 2 should		25. Was case referred to medical						1 Yes		prior to death?	utopsy findings available completion of cause of
F Vital Physician: this certific al director,	0	examiner? 1 XYes 2 Hospital: 1	Impatient 2 🗆 E		3 □ DOA	Other: 4 [	Death (Check of Nursing Hom		dence 6	Other (Spe	cify)
Sion of Attending death. ctor: After y the funding the	Certificate	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place	of injury h, Day, Year)  of Injury - At hon ng, etc. (Specify)	28b. Time of injury	M ·	njury at work? 1 □ Yes ice	2 🗆 No	3d. Describe h  8f. Location (S  City or Tow	Street and	d Number or Ru	ural Route Number,
Division to the Hospital or A within 24 hours after To the Funeral Director Completely filled in Division Madrical Control Con	Medica	29a. Certifier (Check (Check only one) (Check one) (Check only one) (Check one) (Che	is of examination a	and/or investig	ation, in my o	pinion dea	ath occurred at the	ne time date a	nd place	and due to the	cause(s) and manner stated
To t with To to com	4	9b. Signature and title of certifier  Lony	91	D		ense numb	356	.	29d. Dat	te signed (Mont	h, Day, Year)
		0. Name and address of person who completed caus	e of death (Item 2	23a) (Type, Pri	nt) 5	200	UPPE	Ch	esc	peal	of ZIOIL
State Registrar		1. Date filed (Month, Day, Year) (32. R	istrar's Signatu	e A. A	Berton					7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ruth Adeline Gambill 21 2012 Medical tunus a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Rehabilitation
6. Sex 7. Age (III If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 212-50-2715 **Director** 1 □ M 2 🔀 F 99 Oct. 7, 1912 North Carolina Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at rector 28a-f 1 🗌 Yes 2 🔀 No Maryland Harford Bel Air ۵ ms 23a or must be r Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2110 White House Road 21015 USA al Hygiene. dother than "natural", or item: event, the Medical Examiner m 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Wildowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Farmer Dairy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Samuel Denson Poplin t. Page 1 and 2 should be tment of Health and Men tant: If item 27 is marke traumatic Jettie Ether Gambill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwyndolyn G. Poole / Daughter 2133 White House Road, Bel Air, MD 21015 saltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If i any injury or conce. 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Bel Air Memorial Gdn. 8-27-12 4 Donation 5 Other (Specify) Bel Air, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A
50 W. Broadway, Bel Air, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4  $\square$  Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615W MACPHAIL RD \$106, BELAIR, KHOSCA

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year,

2 8 2012

GAMB: 1

32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Box 68760

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:33 Netnan Medical Crahan 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign **Funeral** (MOOTE/12/1957 Coultharyland 220-64-6133 1**2** M 2 □ F 55 Director 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 🗆 No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 808 Painted Post Court 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 22 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Counselor Healthcare traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Nathaniel Graham permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic volee. Ruth Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brandy Ericka Graham / Daughter 3658 Clifmar Road, Windsor Mill, MD 21244 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Chesapeake Crematory 8/27/2012 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** asnalo Sequentially list conditions Examiner it any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a dur sequence of); Mell-1-5 attending physician and for use as the burial-transi To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 \_\_ Live Birth 2 \_\_ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 1 Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 2 No Other: 1 🗌 Yes မ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury Accident 2 🗌 No Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar J-

5401

32. Registra

Physician/

Medical

Examiner

Funeral

Director

	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		5	10a. State	10b. County		10c. City, Tow	n or Loca	ition					10d. Inside City Limits
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5	endir use		<u> </u>	23b. Was decedent	pregnant	23c. If yes, outcome 1 Live Birth	of pregnancy	h 3 🗆	Ectopic pregn	ancy		9	23d. Date of de	livery
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Year Theresa 01ga Griisser August 26 04:05A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Morningside House of Friendship Hanover Anne Arundel Co. 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Months (Month, Day, Year) Hours Min. Director 219-16-2168 1 M 2 X F Yrs 95 10/06/1916 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director MD Anne Arundel Co. Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Cayer Drive 21061 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced Specify: White ntal Hygiene. ced other than "natura c event, the <u>Medical E</u> Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing 10 yrs. Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည t. Page 1 and 2 should be friment of Health and Menta reart. If item 27 is marked jury or other traumatic evices. Michael Griisser Anna Muller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 823 Springdale Drive Millersville, MD 21108 Patricia A. Goralski /Niece 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/31/2012 Holy Cross Cemetery Brooklyn Park, MD Signature of Fun 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Month Year Yes 2 LINO 9 Unknown 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☑ M 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မြ 2 46 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tether (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed care of death (Item 23a) (Type, Print) 0 in 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Anaus Medical 4a. Facility Name of not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CO NORTHWEST HOSPICE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Director 220-52-4086 1 ☐ M 2**X**XF Yrs. 63 OCT, 31 1948 MARYLAND Usual Residence of Deceden show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. It item 27 is marked other then "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No HARFORD CO MARYLAND **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1947 BROOKSIDE DRIVE 21040 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates BLACK Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GIANT FOODS UNKNOWN CASHIER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ROBERT WEBSTER CONSTANCE GIBSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamika Dorsey/Daughter 1407 St.Christopher Cr., Edgewood, Md., 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Department of H Important: If ite any Injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 08-27-12 BALTIMORE, MARYLAND 21. Signature Jupital rvice resee william and Address of Facility COMM FUNERAL HOME-HARFORD, P.A. S PHILA. BLV., ABERDEEN, MD., 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Rectal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physician and for use as the burial-transit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 1 Yes 2 Unknown 5 Other (specify) Month Year Day sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes Division of Vital after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ည 1 🗌 Yes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 D Other 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier nsky apanemo 29d. Date signed (Month, Day, Year) 00057465 8/24/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2835 203 NSRajapakse MD Smill AV 2 31. Date filed (Month, Day, Year) AUG 2 8 2012 32. Registrar's State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST **Physician** 2017 6:50 PM HILTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center n/a Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ₹ M 2 □ F 70 044-48-4781 Director 1942 England Feb. Usual Residence of Decedent the Maryland 10b. County 10c, City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Parkton 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? be filed within 72 hours after death with 5 Quail Hill Court Funeral 21120 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White Specify: þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hyglene. Important: if Item 27 Is marked other than "ratul any injury or other traumatic event, the Medical one. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Johns Hopkins College (1-4 or 5+) 5+ Elementary/Secondary (0-12) University Research Faculty 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should bument of Health and Menta Lawrence Hilton Mary Smallwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Hilton/wife 5 Quail Hill Court Parkton, Maryland 21120 20a. Method of Disposition
1 ☐ Burial 2 🔏 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 08/28/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Stephanie Custer 22. Name and Address of FacilitCremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Doath Immediate Cause (Final disease or condition resulting in death) **Physician** EPSIS /Medical Due to (or as a consequence of): CONSESTINE HEART FAILURE Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 Yes 2 9 Unknown 2 No page 2 should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 □ No this certificate 20 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural

Accident Injury 1 ☐ Yes 2 ☐ No after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760,

24 hours Hospital

INTERN - INTERNAL NEDICINE RES -000 AUGUST 24, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORSTER CHHEAN; MD 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Zachary Hendrix State of Maryland / Department of Health and Mental Hygiene 2012 27385 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle Last) 2. Date of Death Month August 22, 2012 Medical Examiner Hendrix 1938 hrs Zachary 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3603 Clarinth Road Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director Min. 215-17-8015 1 M 2 F 08 16 86 Country) MD 26 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. Baltimore 1 X Yes 2 No 28a-f show MD NA be filed within 72 hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3603 Clarinth Road 21215 Ö Funeral 11 Marital Status I and 2 should be filed within 72 nouss.....
Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, the Medical Examiner must be 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2X No Yes f Yes, Give Year 1 Yes 2 No specify: 4 Divorced Specify: Black ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Unemployed Unemployed 12th grade na 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Laverl Moore Be Reginald Hendrix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3603 Clarinth Road, Baltimore, Md 21215 Reginald Hendrix-Father If item timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Pages 1 1 Burial 2 Cremation 3 Removal from State Department o 8/28/2012 On-Site Baltimore, Md Donation 5 Other Specify. ignature of Funeral Service License Marcard Adres Hof Favilies t 4300 Wabash Ave, Baltimore, Md 21215 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Between Onset and Medical a. Contact Gunshot Wound of Head Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Records, P.O. Box 68760 IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) for 1 Yes 2 No 9 Unknown 9 Unknown After this certificate has been signed by the funeral director, page 2 should be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital 8 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other<sub>4</sub> Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 2 No 28a. Date of Injury FOUND: 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject shot self FOUND: 1 Natural 5 Pending 1 Yes 2 V No death. the Aug 22, 2012 1931 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City within 24 hours after To the Funeral Dire 3 🗸 Suicide 6 Could not be or Town, State) 3603 Clarinth Road, Baltimore, MD determined (Specify) Single Family Home 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 23, 2012 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Yea AUG 28 Registrar's Signature State arks Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G930 8/28/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 10:40 AM Medical County of Death
RaitIMOP'S Facility Name (if not institution, give street and number) 4b. City, Town or Location of Death Examiner 10W50n If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Months Hours Min. Director 1 MM 2 DF Yrs 23a or 28a-f show 10b. County should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at by Funeral Director SOHIMORE 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industr (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) oremar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 21207 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6106 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other g 1 Burial 2 Cremation 3 Removal from State Lores 4 Donation 5 Other (Specify) Synature Funeral Jervice Licey 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Dement's CUN Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Dav Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 百 disease 1 Yes 2 No 3 Probably 4 Unknown , Dup vein certovousular Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 1 No 1 🗌 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 other (Specify) 2 No Hospital: nca 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 🔲 Yes 5 Pending 2 🗌 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2007063 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Pat churres 5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 08 2012 4:30 Marie Harry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** 3162 Elmora Avenue If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs. . Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Hours Director 1 □ M 2 🔀 F 251-50-5166 Yrs 09/08/1918 93 Usual Residence of Dece 10d. Inside City Limits or 28a-f show 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland Director 1. Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 USA 3162 Elmora Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 PNo Black, White, etc. <u>ک</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes Give Specify Completed 3 ₩idowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore Gas And Electric **Building Care** Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Durant Sammie Lee Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26 Heavrin Court, Nottingham, MD 21236 Inez Harry-Rucker / Grand-daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 8/30/2012 Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) King Park Cemetery 22. Name and Address of Facility Signature of Funeral Service Licens Vaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List body one cause on each line. Approximate Interval Between Onset and Death DISPACE Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner entewsion Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran 1.24 hours after death.
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Registrar

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32. Registrar's Signatu

AMEND #25, PER ME G930 8/24/12 TRT State of Maryland / Department of Health and Mental Hygiene 2012 27388 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7 77-Year Physician/ 0140 Howard Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** luniversity of Manyland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Aug 3, 1955 Min. 216 68 1425 Maryland 56 Director 1 🗆 M 2 🛣 F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c, City, Town or Location an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 XX Waldorf Maryland Charles 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 4661 Temple Court 20602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Home Engineer Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည David Lee Harmon Shirley Newman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 3218 Wheaton Way, Ellicott City, MD 21043 Sarah Sa (daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 XXCremation 3 Removal from State Aug 1, 2012 4 Donation 5 Other (Specify) Lee Crematory Clinton, MD 21. Signature of Funeral Serviced 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ intra cranial nemarha disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury CERTIFICATION AD PROVED BY INCO Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

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9 Unknown Month Dav Pregnant at time of death ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be o 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1X Yes 2 ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ithin 24 hours after death the Funeral Director: Aformpletely filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the l within 2 To the l only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 102483 7127/12 M.D. Funta

Registrar

State

Dara Farber

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

225. Greene St. Bultimore

**AUG 28** 

32. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

		-	For State Registrar	State of Maryland		tificate of De			g. No. 2012	27389
ı	Physicia		Decedent's Name (First, Middle, Last)  Jeanne Monroe	Hammond		=		2. Date of Death	25° 201′2°	3. Time of Death 7:00 a M
w .	Medic Examin		4a. Facility Name (if not institution, give stre	eet and number)		4b. City, Town, or L			4c. County of Death	
	Funeral	0	208 Central Ave  5. Social Security Number  6. Sex	7. Age (In yrs. las	t birthday)	Glyndo  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birti	nplace (State or Foreign
	Director ≥		212-20-3491 1 □ I Usual Residence of Decedent					Sept 3	77924 Nar	
	aryland a-f sho ified at	ector	10a. State 10b. County  Maryland Baltimore		Town or Loc yndon	cation				10 <b>d</b> . Inside City Limits 1 ☐ Yes 2 🛂 No
	th the M 3a or 28 t be not	Funeral Director	10e. Street and Number			10f. Zip Code 21071		10	Og. Citizen of What Co	untry?
	death wi		THAIR Old Co	. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban,		cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
980	rs after or rall, or Examir	ed by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 M No If Yes, Give Year or Dates.		☐ Yes 2 No				nite
215-0	an "natu Medical	Completed	15. Decedent's Educi (Specify only highest grade		(Give k	lent's Usual Occupat kind of work done du O NOT use retired)	tion ring most of worki	ng 1	6b Kind of Business Lectric C	
1212	ad withir Tygiene Ither tha	اما	Elementary/Seconday (0-12)  17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	Admir	nistration T	18. Mother's Name	(First Middle M:	Telephone	Co.
ylan	ld be file Mental I arked o atic eve	인	Ira LeRoy Wales	IV			Vera Mor	roe Wale	es	
Mar	and 2 shou Health and tem 27 is m		19a. Informant's Name/Relationship (Type, James Hammond - soi	· '	19b. Mailin 1322	Address (Street and Laurel Lau	ane, West	Route Number, C minster,	City or Town, State, Zip MD• 21158	Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State 20b. Pla	metery, cren Faiths	sition (Name of natory or other place, cremato	ry 8/2	8/12		ester, MD.
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee		22	Name and Address 1605 Reist	of Facility <b>Eck</b> l terstown	nardt Fur Rd. Owir	neral Chape ngs Misls,	MD. 21117
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one of immediate Cause (Final	ations that caused the death. cause on each line.	Do not ente	er the mode of dying,	such as cardiac o	r respiratory arres	22/11	Approximate Interval Between  Geset and Death
i de un	Physician/ Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	ence of):	tago	Coro	yac	BYRL	
	Lxammer	ner	Sequentially list conditions, b. If a y, leading to immediate cause. Enter Underlying	Due to (or ès a consucui	mai cf):	3			~-%	
	ecuted and I-transit	Examiner	Cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):					
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89	death certifica ne attending p ed for use as t		23b. Was decedent pregnant	c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of del	
Box	ed ed	Physician/N	in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown		Other (specify)			Month	Day Year
ds, P.O.	juires that the dea on signed by the a uld be detached f	ρ	Part II. Other significant conditions contr	ibuting to death but not resu	Iting in the u	nderlying cause give	en in Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	The law requires that the ate has been signed by the page 2 should be detach	Completed						24a. Was an autopsy perform 1 \(\sum \) Yes 2	prior to death?	topsy findings available completion of cause of
ital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No	spital: 1  Inpatient 2 E	TD/Outrotion	Other	ce of Death (Check		nce 6 🗆 Other (Spec	16.1
on of V	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	icate: To	27. Manner of Death  1 Satural 5 Pending 2 Accident Investigation		28b. Time of injury	28c. Injury work?	at	28d. Describe how		
Division	tal or Atters after der al Directored in by the	Il Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stro City or Town,	eet and Number or Rui State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Diraccompleted filled in I	Medical	(Check   Medical Examiner	an: To the best of my knowle on the basis of examination Practioner: To the best of my	and/or invest	tigation, in my opinior	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	-	29b. Signature and title of certifier	m		29c. License			Od. Date signed (Month	
A SECOND	10V		30 Name and address of person who com	pleted cause of death (Item :	23a) (Type, F	Print)	( < 1	116	'a=1 11	MAD OUR
	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's Signatu	Irel A	S. Centi	VOI.	WESHY	III) XUV	HUZHU
	Registr	<b>:</b>	KHE 2 8 70	/ / Dayword /	14 July 1	B-0 W-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 27390 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Harry Humphries 1537 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** Director 577-68-0239 1**X** M 2 □ F 61 Jan 9 1951 DC Usual Residence of Deceden 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1221 M. Street NW 20005 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important If item 27 is marked Atheria 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify:Black Completed 3 Widowed 4 X Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Private 3rd Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) မ Harry Mitchell Vivian Humphries Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1846 Alamaba Ave SE Washington DC 20020 Claudia Jones 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Aug Riverdale Park Riverdale 4 Donation 5 Other (Specify) Md 2012 22. Name and Address of Facility McLaughlin Funeral Home 518 PA Ave SE Washington DC 20020 23a. Part 1. Enter the diseas shock, or heart failure. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin SPECTRUM BETA LACTAMASE KLEBSIGLA attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year signed by the at d be detached for 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen RENAL FAILURE Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Iniury at within 24 hours after death.

To the Funeral Director; After to completely filled in by the funer 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4  $\square$  Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person

31. Date filed (Month, Da AUG 28 300! HOSPITAL DR.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar  1. Decedent's Name (First, Middle, Last)		007	incate of E		2. Date of Dea	1eg. 110	3. Time of Death
н	Physicia		Leoda Ellen	Hinckle	9			August	24, 2012 Year	
Strang.	Medic Examin		4a. Facility Name (if not institution, give stree	•		4b. City, Town, or	Location of Dea		4c. County of De	
negrado ()			1825 Mitchell Dri	ve		Aberdee	en		Harfor	d
	Funeral Director		5. Social Security Number $6. \text{ Sex}$ $217-18-8594$ $1 \square \text{ M}$	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, Year) C	irthplace (State or Foreign country)
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	yland -f sho ed at	Director	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
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ary	nd M nd M s mar		19a. Informant's Name/Relationship (Type, F		19b. Mailin	a Address (Street a			City or Town, State, 2	Zip Code)
Σ	d 2 shalth a alth a 27 is		David T. Hinckle /	Son					el Air, MD	
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<u>ï</u>	Page ment ant: I		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Ponation 5 ☐ Other (Specify)	Oval II Ottato	ford Me	emorial C	dn. 8-2	29-2012	Aberdeen,	-
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eco	has be	ldw	LINKONIC ATT	rul tibri	MANZ	7 <u>n</u>		- autop	sy prior to	completion of cause of
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Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	<ol> <li>Place of Injury - At hor building, etc. (Specify)</li> </ol>		et, factory, office		28f. Location (S City or Town	treet and Number or F n, State)	Rural Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		On the basis of examination	and/or invest	igation, in my opinic	on, death occurre	d at the time, date ar	nd place, and due to the	e cause(s) and manner stated.
	To th within To th comp		29b. Signature and title of certifier			29c. License		1	29d. Date signed (Mor	
			I Marrie Mis	MD		D19	583		August	24,2012
			30. Name and address of person who comp	eted cause of death (Item	23a) (Type, P	rint) &	en S	Tree!	Khova	een.
			31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ny Ire.	7	Mary	and !	21001	
	Stat Registra		AUG 2 8 2012	oz. Negisirai s signati	parks					

DHMH 17 Rev 06-2011

amend 29c, per DVR, e930 8-29-12 SM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#1 perp HYS G930 8/28/2012 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1130 AM Year **Physician** 08 22 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner POWERBACK REHABILITATION CENTER Baltimore County Lutherville If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 M 2 New York 205-20-7641 85 Director 12 13011926 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural" or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore County Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 USA 515 Brightwood Road Funeral 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ White 3 ☐ Widowed 4 X Divorced Completed Medical 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Secretary Brokerage Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John L. Sullivan Isabelle Kreahn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 19a. Informant's Name/Relationship (Type. Print) William F. Blue, Esq. (Attorney) 102 West Pennsylvania Ave., Suite 600, Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 8/23/2012 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Fungal Server ee Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 000 mu , /Medical (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mon 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Nes Completed 24a. Was an 1□ Yes Hospital or Attending Physician: 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient Certification: To Manner of Deati 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only and manner stated. within 24 29d. Date gree (Month, Day, Year) 29c. License number 29b. Signature and title of cept D56775 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w Rasha Morad, MD, 515 Brightwood Road, Lutherville, MD 21093

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Clayton Conrad Holland	State of Maryland / Department of Health and Mental Hygiene

2012 27393

		1- For State Registrar		Cert	ificate of	Death			Reg. No.	201	2 2133	
Physic	ian/	Decedent's Name (First, Middle	Decedent's Name (First, Middle,Last)							Year	3. Time of Death	
Medical Exam	iinei	oraj com comi						Month August 2		2	1421 hrs	
		4a. Facility Name (if not institution 139 S. Central Avenue			41	b. City, Town, o Baltimore	or Location o	f Death	40	c. County of Death		
Funera		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las	t birthday)	If Under 1 Ye			irth (MM	/DD/YYYY) 9. Birt		
Director		242-37-4942 Usual Residence of Decedent	1 M 2 F	36	Yrs.	Months Da	ys Hours	March	11,	1976NSP	cty) Carolina	
ru A		10a. State 10b. County		10c. City, T	own or Location	n	-				10d. Inside City Limits	
and show :	_	Maryland Baltin	nore	Balt	imore						1 X Yes 2 No	
arylar 8a-fs	윷	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Coun	itry?	
0036 within 72 hours after death with the Maryland signer. heer than "natural", or teems 23a or 28a-f she Medical Examiner must be notified at once	Director	139 South Cent	ral Street			21202			U.	S.A.		
th with	Funeral	11. Marital Status 1 X Never Married 2 Ma	12. Was Decedent Armed Forces?	Ever in U.S.		Decedent of H	ispanic Origi an, Mexican,	in? ( Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Americ White, etc.	can Indian, Black,	
fter dea	Ful		1 Yes 2	X No		Yes 2X N		,		Specify: Whi	te	
ours al atural	d b	15. Decedent's Education (Spec	or Dates: ify only highest grade com	pleted) 1	6a. Decedent	s Usual Occupa	ation (Give k	ind of work done		Kind of Business/Ir		
16 n 72 ho ian "m	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	-	st of working lif	e. DO NOT u	use retired)	1 5			
within giene.	E	17. Father's Name (First, Middle, I	4		Chef		40.44	N (5) ( No. 1 II)		estauran	t	
) 21215-0036 rould be filed within 72 hours after of defental Pygiene, is marked other than "natural", on the oven, the Medical Examiner.	Be C	Robert W. Holls						Rominger	Maiden	Surname)		
imore, MD 21215- Pages 1 and 2 should be filed ment of Health and Mental Hyg tant: If item 27 is marked out or other fraumatic event, the	၉	19a. Informant's Name/Relationsh Ina R. Holland	ip(Type, Print) (Mother)						Rural Route Number, City or Town, State, Zip Code) Rd., Lenoir, NC 28645			
日 日 田 日 日		20a. Method of Disposition		20b. Pla	ace of Dispositi	on (Name of ce		Date		Location - City or		
Baltimore, permit. Pages I an Department of Hee Important: If ite injury or other tr		1 Burial 2 X Cremation 4 Donation 5 Other Spe		Met	ematory or othe ropolit	'	natory	8/23/12	A1	exandria	. VA	
Baltimc permit. Page Department Important: injury or otl		21. ignature of Funeral Service						meral Ser			,	
		Lemmo	bum		1 551	7 Vine	St.,	Alexandria	a. V	A 22310		
Physician /Medical		23a. Part I. Enter the disease, or of failure. List only one cause of	complications that caused to on each line.	the death. D	o not enter the	mode of dying	, such as ca	rdiac or respiratory ar	rest, sho	ock, or heart	Approximate Interval Between Onset and	
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	quence of):								
ed 1sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of);								
Division of Vital Records, P.O. Box 68760, ra for afterding Physician: The law requires that the death certificate be executed are aftered. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial – transi	/Medical	X UNPENDED	d.  AMENDED 23a,	27,28	Ba-f,pe	r me,g9	31 9-6	6-12 sm				
760, ficate be es g physician the burial	Med	IF FEMALE;	23c. If yes, outcom	e of pregna					230	d. Date of delivery		
687 certific ding p	ian/	23b. Was decedent pregnant in the past 12 months?	L CIVE DITU	ima of dooth	. =	I death 3	Ectopic	pregnancy		Month Da	ay Year	
Box 68' e death certifi the attending	Physician	1 Yes 2 No 9 Unkn	own 9 Unknown	ime or dear	5 Othe	r (Specify)						
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Divis  Divis  To the Hospital or A within 24 hours after To the Funeral Dire  completely filled in b		29a. Certifier (Check only 1 Certifying Phy	sician: To the best of my					e, and due to the caus	se(s) and	d manner as stated		
Sough in the state of the state	Medical	2 medical Exam 29b. Signature and title of certifier	iner:On the basis of exam and manner stated	auon and/	or investigation	1, in my opinior		aned at the time, date				
		A A A	THA -	7		O.C.				Date signed <i>(Mont</i> ust 22, 2012	n, Day, rear)	
y		30. Name and ddress of person w	the completed cause of do	ath (Item 23	ta)				"ug			
	ļ	Melissa Brassell, MD	Assistant Medical I			Baltimore S	Street, Bal	ltimore, MD 2122	23			
S	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	be del							
Regis	rar	AUG 2 8 2012	(Auna)	A. A	-							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AŬĞUST 2012 7:40 AM FRANKLIN H. HUBBARD, SR Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Davs Months Hours (Month, Day, **Director** 1 **X**M 2 $\square$ F 219-01-6087 2-25-1921 91 MARYLAND 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD BALTO. MIDDLE RIVER 1 Yes 2 XNo 10e. Street and Number ò 10f. Zip Code must be 10g. Citizen of What Country? Jubbard, FRANKlin Funeral 23a4023 BAY DRIVE 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black White etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 ₩Widowed 4 □ Divorced Specify: Year or Dates.1942-1945 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ESSKAY MEATS 11THTRUCK DRIVER or other traumatic event, Be 17. Father's Name (First, Middle, Last, and Mental F is marked o 18. Mother's Name (First, Middle, Maiden Surname) ٩ WILLIAM HUBBARD EMMA OVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Department of Healt Important: If item 2 any injury or other once. FRANK HUBBARD. .IR 4023 BAY DRIVE MIDDLE RIVER, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗶 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) PARKWOOD 8-25-2012 PARKVILLE, MD. Signature of Funeral Service Lice 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part 1 Enter the disease, shock, or heart failure. Lispplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it dry, leading to in rediate cause. Enter Underlying Examir 15 chemic Cause (Disease or injury and that initiated events resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day the Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 Yes Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an certificate has autopsy page perform 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 1 Yes Other: မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Man of Death 28a. Date of injury 28b Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending After (Month, Day, Year) 1 Natural 5 $\square$ Pending Accident Suicide 1 Yes 2 No Investigation Funeral Director: stely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

within 7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ynthia Sociano MD 6701 N Charles St Baltoniore Mg 21204

Cynthia macio us

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

00051347

# Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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C		Potomac Valley Nursing and Wellness Ct  5. Social Security Number   6. Sex   7. Age (In yrs. last birt							8. Date of Birth		Montgomery  9. Birthplace (State or Forei		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married	Armed Forces?  1  Yes 2 X		If Y	es, specify Cuba	n, Mexican,				Black, White,	etc.	
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g Phy er this eral d	te: To	1   Inpatient 2   ER/Outpatient 3   DOA   4   Nursing Home 5   Residence 6   Other (Specify)   27. Manner of Death   28a. Date of injury   28b. Time of   28c. Injury at   28d. Describe how injury occurred											
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge, de	eath occ	cured at the time,	date and pl	lace, and d	ue to the cau	se(s) and ma	anner as stat	ed. ause(s) and manner stated.	
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State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr A wend hiracha 9043 Shody Grove

31. Date filed (Month, Day, Year)

AUG 2.8 2012

DHMH 17 Rev 7/2009

MD 208 74

Court Gaithershing

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician/ 9:35PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Country Home Assisted Living Harwood Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min (Month, Day, Year) Director 218-66-6538 1 🗆 M 2 🗓 F 69 Sept. 12, 1942 Hungary il Hygiene. I other than 'natural'', or Items 23a or 28a-f show vent, the Medical Examinar must be notified al. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter deeth with the Marylend Director 1 Tes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9323 Kendale Road 20854 United States 12. Was Decedent Ever in U.S. Armed Forceş? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Radiologist Medicine other traumatic event, 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental H .. Pege 1 end 2 should be fill tment of Heelth end Mental tsnt: If Item 27 is msrked o မ Joseph Horvath Klara Kiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Peter Pushkas/Husband 9323 Kendale Road, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 25 Dapertment of I Importent: If its any injury or of once. 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium 4 Donation 5 Other (Specify)  $\bar{2}012$ Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ogset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). is certificate hes been signad by the ettending physicien and director, pege 2 should bs detached for use as the burlei-trensit To the Hospital or Attending Phyeician: The law requires thet the deeth certificate be executed within 24 hours efter death.

To the Funsrai Director: After this certificate hes been signad by the ettending physicien and completely filled in by the funerel director, page 2 should be detached for use as the burlei-trensi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P,O, Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 **Division of Vital** 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 ☑ No ည 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 ☐ Accident
3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 Certifying Nurse Practition only one)

State

Registrar
DHMH 17 Rev 06-2011

Print)

(Item 23a) (Type,

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of death

32. Registrar's Sign

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Ethe1 Miller Horton 2012 16 5:00 P M August Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home and Village Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 146-14-6164 1 🗆 M 2 💢 F March 1, Usual Residence of Dece 1924 New Jersey 28a-f shov il Hygiene. I other then "netural", or Items 23a or 28a-f shoi vent, the Medicel Examiner must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9701 Veirs Drive 20850 United States 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 M Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Administrative Assistant U. S. Government of and 2 should be filed worked Hygi of Health and Mental Hygi fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ George Miller Ethel Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any Injury or other tr Barbara H. Farr / Daughter Pleasant Acres Court, Thurmont, Maryland 21788 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Unk. Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee Robert Address Frankey Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) Examiner OUVS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physicien I for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day ed by the a g Unknown g Unknown P.O. been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, **Completed I** 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate hes is funeral director, page 2 a autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ Ne 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After this etely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hour To the Funer completely file 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier d. Date signed (Month, Day, Year) 4908 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles W. Karesh, M.D. 9701 Veirs Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 8 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27398 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Deat Physician/ AYTOUS 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death anafo Juynn Baltimore ()ax 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year Sep 21, Davs Hours Min. Country)
District of Co Director 58 579-72-5726 1 □ M 2 🔀 F 1953 Yrs 28a-f show 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d, Inside City Limits 1 Yes 2 No MD Baltimore Gwynn Oak 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1557 Langford Road 21207 United States items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 72 hours after ō δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Specify: 3 Widowed 4 ☐ Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Care Nursing Assist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve ည Unk Unk Mary Jane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Hunter /Son 3870 Chasemont Drive Powder Springs, GA 30127 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State etery, crematory or other place Aug 28 4 Donation 5 Other (Specify) Beltsville, Maryland 2012 Chesapeake Crematory 21. Signature of Funeral Service Licenses 22. Nacceand Address of Family Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GALLRIA disease or condition resulting in death) Medical Due to (or as a consequence of) **d**Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for u in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No q | Linknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has perform 2 🗌 No 1 ☐ Yes 2 ☐ 1 Yes 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Be Hospital Other: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner Leath 28b. Time of Certificate: 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c, License number and address of person v who completed cause of death (Item 23a) (Type, Print) State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 27399 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Y*e*er **Physician** 10:45 P 2012 ISAACS MACEASA /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Spring widow baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 M 2 F Yrs. Director 17.52.0229 30-1948 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other then "natural; or items 23e or 28e-f show traumatic event, the Medical Examiner must be netified at 1 Yes 2 No Directo Baltimore mp mil Dunsing 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Spring widow Court 1117 USA 5120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after of death and Mental Hygiene. In 27 is marked other then "natural", or iter 1 ☐ Yes 2 ☑ 1 To If Yes, Give Year or Dates: 1 Never Married 2 Married Specify Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: À 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professor NAMBHA PHD 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be THOMAS ISAACS Dorothy Drooks ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health an Important: If item 27 is many injury or other. 20b. Place of Disposition (Name of campetery, crematory or other place)

Date 20 Location - City or Town, State 2.1117 SOLAYA TSARCE DAughter 20a. Method of Disposition 1-12 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State historiown, MD JANRS un 01 \* 4 ☐ Donation 5 ☐ Other (Specify) in walley tuneral Service 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximated Cause (Final disease or condition) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility KEnne Approximate Interval Between Opser and Death leas Endon months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physician and use as the burial-transit that initiated events the death certificate be execuresulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical signed by the attending to be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death Check on one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2/No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date/signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier N Charles Street Baltimore MD 21212 completed cause of death (Item 23a) (Type, Print) alchor 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SAACSON Month 2012 Medical 6:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Inpatient Care Center Harwood Anne Arundel Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 09/26/1947 Country) California Director 1 M 2 D F 546-76-9158 64 Yrs hould be filed within 72 hours a.e... end Mental Hyglene. is marked other than "natural", or items 23e or 28a-f show .....ette event, the Medical Examinar must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director N Yes 2 □ No MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9520 Muirkirk Road, Apt. 201 20708 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 Nevy 1 ☐ Yes 2X☐ No Specify: Completed 3 Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Commercial Be permit. Page 1 and 2 should be filed Department of Heelth and Mental Hy important: if item 27 is marked oth eny injury or other trailment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Isaacson Ivv Deards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ineko Isaacson / Wife 9520 Muirkirk Road, Apt. 201, Laurel, MD 20708 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 8/29/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Doro<u>ta Marshall</u> Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Plant and Plant Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law required to the attending physicien and within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burlai-transit use (Disease of hijur that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death Year g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examina 3 Certifying Nurse Practitioner: To the best Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 1438 72012

State Registrar NSE

MD2140)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's

8 2012

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D'ay

State Registrar 29b. Signature and title of certifier

TRACIE L. MORGAN, CRNP 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

AUG 2 8 2012

32. Sgistrer's Signature

A. Sauce

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

30270

TIMONIUM, MD 21093

29d. Date signed (Month, Pay, Year)

AMEND #25 PER ME G930 8/24/12 TRT State of Maryland Department of Health and Mental Hygiene State
Registrar 27402 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 11:34Ам Month Day JACKSON AUG 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death HAR BOR HOSPITAL ALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours **Director** 219-32-4020 1 🖾 M 2 🗆 F Jan. 16, 1937 Usual Residence of Decedent Marvland permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🄀 No Maryland | Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S.A. 603 Cedar Hill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Welder Ellicott Machine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Jackson Fox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harriett E. Jackson (Wife) 603 Cedar Hill Road Brooklyn Park, Maryland 21225 20a. Method of Disposition
1 X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Glen Haven Mem. Pk. 4 Donation 5 Other (Specify) 08/22/2012 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee MOO-732 McCully-Polyniak Funeral Home, P.A. 130 Fast Fort Avenue Baltimore, Maryland 21230 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph<sub>sician</sub> Cerebrovashulo. disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 9 daily Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury MEDICAL EXAMINER the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and Abia T-ubn signed by the attending physician and defached for use as the burial-trar that initiated events resulting in death) Last FION APPROVED BY Due to (or as a consequence of) CERTIFICA Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Kidney 24a. Was an autopsy performed Yes 2 X No 1 🗌 Yes 2 🖾 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 XYes -2-100 Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours Medical 🛮 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 2 Cakshim Nestyea. MD 706 Aug 17th 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAKSHMI N POTAKHOVIL, IND 3001 S HANOVER Store! Buttimore, MD = 21225 31. Date filed (Month, Pay Year) AUG 28 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Doris Mary Jacobson : 20 PM Medical Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** rsin9 avre If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. ast birthday) Funeral 1 M 2 🛛 F Month, Day, Months Hours Mary land 1920 91 216-01-2988 Director Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10b. County 10c. City. Town or Location filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral USA 2008 Helton Ave. 21015 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White, etc. , o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 U.S. Government Editorial Assistant Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Hugh George Hamill Bertha Catherine Hayne permit. Page 1 and 2 shoul Department of Health and I Important: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Temple Court, Bel Air, MD 21015 Creighton P. Jacobson / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Harford Memorial Gdn 8-27-2012 4 Donation 5 Other (Specify) Aberdeen, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licensee ODDICA 1317 Cokesbury Road, Abingdon, Maryland 21009 (Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** 5-quertially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown Division of Vital Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by YNie 1 Yes 2 No 3 Probably 4 Unknown 4b. Were autopsy findings available 24a. Was an prior to completi death? autopsy duni performed certificate l 2 🗹 No 1 Yes director, Be 25. Was case referred 26. Place of De (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) o 24 hours after death.

e Funeral Director: After this leted filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manuer of Death 28b. Time of 28d. Describe how injury occurred 5 Pending ✓ Natural Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

ess of person who completed cause of death (Item 23a) [Type, Print)

32. Registrar's Signature

(Month, Day, Year) 2 8 2012

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012  $\mathbf{P}$  M 1:00 Murray Edwin Jackson, Jr. August Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 220-50-6973 Director 1 🗶 M 2 🗆 F 64 February 20, 1948 | Maryland Usual Residence of Dec works I 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at rector 28a-f 1 X Yes 2 No Maryland Rockville Montgomery ā 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō 23a Funeral Examiner must 1222 Clagett Drive 20851 United States or items ould be filed within 72 hours after death ord Mental Hygiene. marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? 1 X Yes 2 □ No If Yes, Give V Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Year or Dates. Vietnam Specify: White 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the ! Bailiff District Court Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic even one. ပ Edwin Kathleen Zeller Murray Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1222 Clagett Drive, Rockville, Maryland 20851 Priscilla M. Jackson / Wife 20a. Method of Disposition
1 █ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August Parklawn Memorial Park Rockville, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furral Service Licensee Robert A. Fumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1/riter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 Jackson, Murray Edwin, Jr. as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic prog. 5 Other (specify) Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 2 No 1 Yes 2 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown page 2 should To the Hospital or Attending Physician: The law requin within 24 hours after death.

To the Funeral Director: After this certificate has been: Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 2 No Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🗓 No 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 5 Pending 2 🗆 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D71462 August 21, 2012

Registrar DHMH 17 Rev 06-2011

8/21

Dan Danila, MD 8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 27405 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August insmoun 0537 AM — James Gamble Kinsman 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Baltimore Catonsville Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. 1 🕅 M 2 🗆 F August 15. 90 1922 Nebraska Director 216-18-0621 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at ould be filed within 72 hours after death with the Maryland ind Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 🗆 Yes 2 🔀 No Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 715 Maiden Choice Lane CC-520 21228 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. 2 no 1944þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify 3 Divorced 1946 Specify: Completed white Year or Dates other traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Community Service Y.M.C.A. Director Be permit. Page 1 and 2 should be filed.
Department of Health and Mental H.
Important: If item 27 is marked ofl any injuy or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Dennison Kinsman Margaret Elizabeth Gamble 19a. Informant's Name/Relationship (Type, Print)
Mae H. Kinsman / wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Maiden Choice Lane, CC520, Catonsville, MD. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc 4 ☐ Donation 5 ☐ Other (Specify) 08/29/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc of Funeral Service Licens Stephanie Custer 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final 2000-2012 Endstage Pnysician/ disease or condition resulting in death) Multiple Medical Due to (or as a own sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 e attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ned by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed should 24a, Was an 24b. Were autopsy findings available prior to completion of cause of s certificate has blirector, page 2 s autopsy performed' death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No □ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed To the Within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) CRNP R144682 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathy Davis Catonsville MD 21228 709 Maiden Choice Luirer 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

AUG 28

			Plea AMEND #25, PER	se Type or Pr	int in Bla	ick Indelible Inl	k. Ensure	All Copies	Are Leg	gible.	
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			Registrar  1 Pecedent's Name (First, Middle,	Last)		Certificate of L	Jeaur	0.0. (0	Reg. No.	112	3. Time of Death
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	Examir	ner	4a. Facility Name (if not institution,	Hopkins	Hosy	etal B	Location of Death	ae (it	4c. Count	y of Death	
	Funeral Director		5. Social Security Number 071–16–5036  Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. last b	irthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 9/18	Year)	9. Birthpl Counti	lace (State or Foreign ry) NY
	faryland Be-f show	Director	10a. State 10b. County	ltimore	10c. City, To	wn or Location Tim	onium	·-		10	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the N 23a or 20 ust be not	Funeral Dir	10e. Street and Number 2525 Pot Sp	rings Road,	, Apt S3	10f. Zip Code	21093		10g. Citizen of		ry? SA
9036	permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Inportant: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1  Yes 2 If Yes, Give Year or Dates.	?	13. Was Decedent of H If Yes, specify Cuba 1  Yes 2 X No		ecify Yes or No- Rican, etc.)		ce - America ck, White, e	
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Baltimore. Maryland 21215-0036	nd 2 should saith and h n 27 is me er trauma		19a. Informant's Name/Relationshi Anne Louis	p (Type, Print) e Duggan /	Daughte	9b. Mailing Address (Street and Street & Communication of	and Number or Rui SWay	al Route Number, BAltimo	City or Town,		ode)   212
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ンタナ	hysici his ce al direc	잍	1 X Yes 2 100			Outpatient 3 DOA Other	4 ☐ Nursing H	ome 5 🗆 Reside	ence 6 🗆 Oth	er (Specify)	
もろをみす ion of Vital	To the Hospital or Attending Physicien: within 24 hours after death,  To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	27. Manner of Death  1	ation	ay, Year)			28d. Describe ho	ow injury occurr	red	
<i>₹</i> Division	oital or At urs after o rral Direct		4 ☐ Hornicide determin	ned 28e. Place of In building, et	c. (Specify)	arm, street, factory, office		28f. Location (St City or Town	n, State)		·
	the Hosp thin 24 ho the Fune mpletely f	Medical	(Check 2 ☐ Medical Ex only one) 3 ☐ Certifying I	aminer: On the basis of	examination and	, death occurred at the time or investigation, in my opinion	on, death occurred a the firme, date and pl	t the time, date an	d place, and du	e to the caus	se(s) and manner stated.
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29b. Signature and title of certifier	mo		29c. License	e number EG - 60	ع عو	Pate signe Angu	d (Month, Da	ay, Year) 1012
11-	120		30. Name and address of person w	5 mo			or leav	st.	Balt	Man	Mnzhn
13	Stat Registra	-	31. Date filed (Month, Day, Year)  AIIC 2 8		rar's Signature	back					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Day Charles L. Kelly OO PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Center timose Funeral Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign . Social Security Number 216-44-0486 Hours Country) 69 **Director** 1**№** M 2 🗆 F MD Feb. 16, 1943 Jud be filed within 72 froms are...
Id Mental Hygiene.
marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 538 Hopkins Landing Drive 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗷 No Black White etc. 1X Never Married 2 ☐ Married þ 1 Yes | CDCK | ES | Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) MD State Elementary/Secondary (0-12) College (1-4 or 5+) State Worker 12th Highway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charlotte C. Thomas John Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, George Gosnell /friend 62 Spring Knoll Court Colora MD 21917 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore MD of Juneral Service Lig 22. Name and Address of Facility Ave. Balto, MD of Essex 21221 300 MAce Home Connelly Funeral 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final hysician/ disease or condition resulting in death) Medical Dụe to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a porsequence of cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph d for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Dav Year 2 No ed by the a detached 9 Unknown Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidney I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed Yes 2 WNo 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending nours after death. neral Director: Aff filled in by the fu М 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier completely 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and addre eted cause of death (Item 23a) (Type, Print) 10 Flanklin Square Drive, Baltimore mo 21237 eung.mo 9000

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 27408 State Registrar Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ GERDY Day 2H Kidwell Year 2017 11:55PM Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death University Membera Baltimore, MD d If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours **Director** 215.40.9322 1**XX**M 2 □ F 70 AUG 14, 1942 MD Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CAROL I NE DENTON 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 1231 FAIRFIELD CT. 21629 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Race - American Indian Armed Forces Black White etc. þ 1 Never Married 2 XX Married 1 XX Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Year or Dates WHITE or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) POLICE OFFICER RAILROAD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH F. KIDWELL JR. MYRTLE PFIEFER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE KIDWELL WIFE 1231 FAIRFIELD CT. DENTON, MD 21629 20a. Method of Disposition
1 ★ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit, Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State cemetery, crematory or other place) 08/30/2012 MDVETCEM CROWNSVILLE 4 ☐ Donation 5 ☐ Other (Specify) CROWNSVILLE, MD 21. Signatule of Funeral Service Lic 22. Name and Address of Facility FINK FUNERAL HOME, P.A. K. CRECORY FIN 426 CRAIN HWY SW GLEN BURNIE MD 21061 M01148 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -ntaration Physician/ Myocerdial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy5 ☐ Other (specify) Month Pregnant at time of death Day Year g Unknown q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 Tes 잍 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) affect Do 8/24/12 AU4176435P102338

Registrar

DHMH 17 Rev 06-2011

State

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31. Date filed (Month, Day, ¥ear)

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Werene St. Beltimor, MD

			_ For	<b>e Type or Pr</b> State of M		d / Depa	artment of	Health		1ental Hy	giene		
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	MC T		Usual Residence of Decedent	A	_					July 1	5, 1938	3 West	Virginia
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9	er dea or ite miner	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Married</li></ul>	Armed Forces?	2	- 11	Yes, specify Cu	ban, Mexica	n, Puerto	Rican, etc.)		Race - Amer Black, White	
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	To the Hospital or Attending Physician; The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Medical	(Check 2 Medical Exa	nysician: To the best o miner: On the basis of urse Practitioner: To th	examination	and/or invest	igation, in my opi	nion, death o	ccurred at	the time, date a	and place, and	due to the c	cause(s) and manner stated.
_	To the within To the Comp	_	29b. Signature and title of certifier	has a	1			nse number			29d. Date sig	gned (Month	n, Day, Year)
•			20 Name and address	MINI	dooth ///	W) (Time )	I DI	3CH	)5		HUGU	ot 2	3,2012
XI			30. Name and address of person when Manuel Lazar	to completed cause		23a) (Type, P	treet	Alber	dee	n	D 21	100	
	Sta		31, Date filed (Month, Day, Year) AUG 2 8 2012	A 32. Registr	rar's Signati								
,	Registr	al .	HUG A O ZUIZ	mun > p	. 400	was							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep				
			110310	rtificate of Death		g. No. 20	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 20 201	3. Time of Death
	Medic		Andre King  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deatl	August	4c. County of De	
1	Examin	er	Holy Cross Hospital	Silver Spring	1	Montgome	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		9. B	irthplace (State or Foreign
	Director		579-06-6243 1 X M 2 □ F 29 Yrs.	Months Days Hours Min.	(Month, Day, Ye		shington, DC
	nd how at		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Li	ocation	1107. 49	1702   1141	10d. Inside City Limits
	larylar 3a-fs iffied	Director	MD Montgomery Silver Sp	ring			1 X Yes 2 No
	the Nor 28		10e. Street and Number	10f. Zip Code	100	g. Citizen of What 0	Country?
	n with	Funeral	11925 Veirs Mill Rd	20906	U	SA	
	death ritem nern		Armed Forces?	Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
36	al", or	d b	1  Never Married 2  Married	1 ☐ Yes 2 X No Specify:		Specify: B1a	
9	hours natur lical E	Completed by	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	6b. Kind of Busines	
2	iin 72 ie. han " e Mec	duo		kind of work done during most of wor OO NOT use retired)	rking	Private	
2	d with tygier ther t	l as l		il Clerk			
anc	ntal F red of	To E	17. Father's Name (First, Middle, Last)  Andre Rawlinson		me (First, Middle, Mai ela V. Kin	,	
37	ould he mark			ing Address (Street and Number or Ru			in Code)
ž	d 2 sk alth a 127 is er trau			48th Ave. Colleg			
ore	of He of He If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposemetery, cre	osition (Name of matory or other place)	Date 20	c. Location - City o	or Town, State
<u><u><u>ä</u></u></u>	. Page Iment <b>tant</b> ; I jury o		4 Donation 5 Other (Specify) Riverdale	Crematory 08-3			, Maryland
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of the Asian Service Litensee	2. Name and Address of Facility $ J_{ {f .}} $			
		Н	23a. Part 1. Enter the disease, or complications that caused the death. Do not en				Approximate
	Physician/		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final Respiratory Fail:				Interval Between Onset and Death
	Medical		disease or condition resulting in death)  a.  Due to (or as a consequence of):				
	Examiner	L	Sequentially list conditions, b. Cardiogenic Shock	:			
	p ##	nine	if any, leading to immediate  Due to (or as a consequence of):	li amuonathu			
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Non-Ischemic Card  Due to (or as a consequence of):	Tiomyopachy			<del> </del>
09	icate be executed I physician and is the burial-transit	dical	d				
6876	certificate be executed inding physician and use as the burial-transi	Med	IF FEMALE:				
	eath certifica attending p	an/	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 \subseteq Live Birth   2 \subseteq Fetal death   3	Ectopic pregnancy		23d. Date of d	
Box	e deat the at thed fo	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		Month	Day Year
P.O.	hat the	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute	to the cause of death?
S,	uires t n sign uld be	ed by	Renal Failure		1 🗆 Yes	2 □ No 3 □	Probably 4 Unknown
0.0	w requ	plete	Liver Failure		24a. Was an		utopsy findings available
Division of Vital Records,	sician: The law certificate has birector, page 2 s	Completed			autopsy performe 1 \sum Yes 2X	d? death?	es 2 No
ta E	cian: ertifica ector,	Be	25. Was case referred to medical examiner?	26. Place of Death (Che			
<u>\</u>	Physic this c	<u>P</u>	1 ☐ Yes 2 X No Hospital: 1 X Inpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of		lome 5 Residence		ecify)
0 [	ding th. After fune	cate	1X Natural 5 ☐ Pending (Month, Day, Year) injury	f 28c. Injury at work?  M 1 Yes 2 No	28d. Describe how	Injury occurred	
<u>S</u>	Atter	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	reet, factory, office	28f. Location (Street		ural Route Number,
<u>≥</u>	tal or rs afte al Dir led in	Ce	building, etc. (Specify)		City or Town, S	State)	
	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attencompletely filled in by the funeral director, page 2 should be detached for	ledical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death (Check 2 ☐ Medical Examiner: On the basis of examination and/or investigation.				
	o the	Me	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier		place, and due to the c		as stated.
	6 4 5 4		A lousse.	D69288		ugust 20,	
			30. Name and address of person who completed cause of death (Item 23a) (Type,		A	ugust 20,	2012
	JV			est Glen Rd. Silv	ver Spring	, MD 210	90
	Stat	е	31. Date filed (Month, Day, Year) 32 Registrar's Signature 32 Registrar's Signature 3.	. 4.1			
	Registra	ır	AUG 20 2012 Claura B. 190	tura-			

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland Registrar	/ Department of F Certificate of D	Health and M Death	lental Hygie	ene 2012	27411
ı	Physicia		1. Decedent's Name (First, Middle, Last) Cletus W. Kenne	11y, II		2. Date of Death	.9° 2012	3. Time of Death 9:13 P M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		Location of Death	nagasa	4c. County of Deat	h
المور	Funeral		Spring House Assisted Living   5. Social Security Number   6. Sex   7. Age (In yrs. last		Spring  If Under 24 Hrs.  Hours Min.	8. Date of Birth	Montgon 9. Bir	thplace (State or Foreign
	Director		385-12-0185 1 M 2 □ F 88  Usual Residence of Decedent	Yrs.		(Month, Day, Ye Oct. 13,	1923 Mich	untry) nigan
	aryland a-f shov fied at	Director		Town or Location				10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	the Ma a or 28a be notii		Maryland Montgomery Bethe  10e. Street and Number	esda 10f. Zip Code		10g	g. Citizen of What Co	
	ith with ms 23s must	Funeral	7911 Sleaford Place	20814				es of America
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates. WWII	13. Was Decedent of Hi If Yes, specify Cubar  1 ☐ Yes 2 ☒ No	n, Mexican, Puerto f	ciry tes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh:	e, etc.
15-0	72 hou n "natu Aedical	Completed	(Specify only highest grade completed)	16a. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)		ng 16	b. Kind of Business	Industry
212	I within ygiene. <b>her tha</b> it, the I	ക		Civil Enginee:	r	Fe	ederal Gov	ernment
Maryland 21215-0036	be filec ental H rked ot ic even	To B	17. Father's Name (First, Middle, Last) Cletus Kennelly		18. Mother's Name Jessie W	(First, Middle, Maio right	den Surname)	
<b>lary</b>	should and M is mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street a	and Number or Rura	Route Number, Cit		<i>'</i>
re, r	l and 2 f Health tem 27 other ti		20a. Method of Disposition 20b. Place	7911 Sleaford ce of Disposition (Name of			Maryland c. Location - City or	
Baltimore,	Page 1 ment of tant: If i		I Bariai 2 2 Oremation 3 B Hemova nont State	netery, crematory or other place omery Crematorium		. 25,	thesda, M	
Balt	permit. Depart Import any inj		21. Signature of Funeral Fervir Licensee  M0089	6 7557 Wiscon	s of Facility phrey Funera nsin Ave.	1 Home/Beth Bethesd	nesda-Chevy a. Marvla	Chase, Inc.
No.	Physician/		23a. Part 1. Enjer the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition and condition and cardinopulmonal and cardinopu	Do not enter the mode of dying ary Arrest				Approximate Interval Between Onset and Death Instant
	Medical Examiner		resulting in death)  Due to (or as a consequen  Failure to Th	·				3 Months
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	execute an and irial-trar	I Exa	that initiated events resulting in death) Last C. Due to (or as a consequent	ice of):				
260	cate be physici s the bu	edical	d					
Division of Vital Records, P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	leath 3 🔲 Ectopic pregnanc:	y		23d. Date of de Month	iivery Day Year
ls, P.O	uires that the signed by	ed by Pr	Part II. Other significant conditions contributing to death but not resulti Anemia	ng in the underlying cause giv	ven in Part I.			the cause of death?
Record	sician: The law req certificate has bee lirector, page 2 shot	Completed by				24a. Was an autopsy performed	d? prior to death?	topsy findings available completion of cause of
/ita	sician: s certific director,		25. Was case referred to medical examiner?  1	Otho	ace of Death (Check		sted Livi	ng Facility
on of \	nding Phy ath. :: After this ie funeral c	icate: T		Bb. Time of 28c. Injury injury work?	at 2	28d. Describe how i		iry)
Division	al or Atte s after de: il Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	1	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	he Hospit in 24 hour he Funera pletely fill	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledd (Check 2 Medical Examiner: On the basis of examination are only the 3 Certifying Nurse Practitioner: To the best of my knowledge.	nd/or investigation, in my opinio	on, death occurred at	the time, date and p	lace, and due to the	cause(s) and manner stated.
	To t		29b. Signature and title of certifier	29c. License			Date signed (Monti	
	13 hr		30. Name and address of person who completed cause of death (Item 23	Ba) (Type, Print)				
	Stat	e	Ravi Passi, M.D., 15245 Shady Gr 31. Date filed (Month, Day, Year) 32. Registrar's Signature		, KOCKV1.	ьте, магу		
	Registra	ar	31. Date filed (Month, Day, Year) 12 32. Registrar's Signature AUG 2 8 2012	Darker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Physician/ Kanga 20T2 Florence 9:25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery National Lutheran Home 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) 350-24-4788 Director 1 □ M 2 🗓 F September 6, 1919 92 United Kingdom I Hyglene. . other then "neturel", or items 23e or 28e-f show vent, tre Medical Exerciser must be myther at 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits Director 1 Tyes 2 No. Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 13606 Valley Drive United Kingdom Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ۵ 1 ☐ Yes 2 🕅 No Specify 3 Nidowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be file nd Mentel F marked o မ Lewis Jacob Margaret Williams ge 1 end 2 should be at of Heelth and Men If Item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13601 Lakewood Court, Rockville, Maryland 20850 Darius Kanga / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Montgomery Crematory or other place)
Crematorium, Inc. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 29 Pege 1 ò Depertment of Importent: If eny injury or once. 4 Donation 5 Other (Specify) Bethesda, Maryland . Signature of Funeral Service Licenses Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 latte on Miga M01305 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physicien: The law requires that the deeth certificate be executed 24 hours after deeth.
 Funerel Director: After this certificate hes been signed by the ettending physicien end burlel-trar resulting in death) Last Due to (or as a consequence of ettending physicien I for use es the burle Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) ed by the deteched g Unknown 9 Unknown Division of Vital Records, P.O. Part II Other significant conditions ath put not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificete hes been signed funeral director, pege 2 should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after deeth.

To the Funerel Director: After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9701 Veirs Drive, Rockville, Maryland 20850 Charles W. Karesh, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 8 2012

State

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ GEORGE KOELBEL 03 47 AM AUG 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY UNIVERSITY OF MARYLAND MEDICAL CENTER Baltimore City Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) **Director** 212-36-6127 1 🕅 M 2 🗆 F 74 10/05/1937 Maryland Usual Residence of Deceden shov or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits Director Queen Anne's Co. Church Hill 1 Yes 2 X No 10e, Street and Number 10g. Citizen of What Country? be Funeral 284 Granny Branch Road 21623 United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian þ 1 Never Married 2 X Married Yes 2 X No Yes, Give 1 ☐ Yes 2 💢 No Specify: Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 yrs. Machinist Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked of t. Page 1 and 2 should be file tment of Health and Mental tant: If item 27 is marked o ပ John Koelbel Anna Neubauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 284 Granny Branch Road Mrs. Betty S. Koelbel / Wife Church Hill, MD 21623 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 08/21/2012 Atlantic Crematory Glen Burnie, Maryland Signature of Funeral Gervice License 22. Name and Address of Facility Singleton Funeral & Cremation M01121 Services PA; 1 2nd Ave. SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HYPOXIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DAY SEPSIS Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying 2 YEARS Cause (Disease or injury that initiated events MERKEL CELL CARCINDMA Due to (or as a consequence of): resulting in death) Last physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Day Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performed Yes 2 X No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No 1 Yes Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation

P.O. Box 68760 Records, Division of Vital within 24 hours after death.

To the Funeral Director: After Hospital or Attending

Baltimore, Maryland 21215-0036

Medical

Could not be

determined

29c. License number NPI 1609142819

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year) AUG

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEL SMITH 22 South Greene St. Baltimore, MD

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) 2012 **AUG 28** 

29b. Signature and title of certifier

Suicide

4 Homicide

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08  $2\overset{\text{Year}}{0}12$ Louise Kenne11 Yvonne 12:58 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Hilltop Road Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** Days (Month, Day, Year) Director 219-52-3233 1 M 2 V 64 06/16/1948 Usual Residence of Deceden permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hijury or other traumatic event, the Modical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Hilltop Road 110 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 DxDivorced Specify. Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housing Company Site Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Warren Kennell Florence Betty Schrock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Tammy L. Lang / daughter 110 Hilltop Road, Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8/24/2012 Atlantic Crematory Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to for as a consequence of: Examiner Sequentially list conditions, if any heading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a contractience of Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 1 Matural 2 Accident 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License nun

State

of death (Item 23a) (Type, Print)

32. Registrar's Signature

s of person who completed ca

31. Date filed (Month, Day, Year)

AUG 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner enter Oh If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Hours (Month, Day, Year) -40-0969 Director 1 🗆 M 2 🛂 F item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1002 Kdaa Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Newer Married 2 Married þ 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☑ Widowed 4 ☐ Divorced SJack Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry t grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sa Ker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 1919 19a. Informant's Name/Relationship (1/10e, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State pemetery, crematory or other 500 Wings 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Foneral MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician/ disease or condition resulting in death) we muelocurous Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted to the Funeral Director. ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Medical Certificate: To 2 140 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Øtner (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

me and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year James R. Lashler 2254M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomen Washington Adventist akoma Park Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Days 27.40. Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Columbia Howare 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral River Parkway Snowden 21045 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. African ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Home Improvement Sand Blaster 12th grade Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fisher is marked of ပ Emmitt Lashley Nellie Kobinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lastler (WIFE 81010 Snowden River Dourkway Columbia MD 21045 Glenda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 2012 Park Cemeters Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services Road Randal Stown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RESPIRATORY ACUTE -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA ASPIRATION Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury TRACHEOESOPHAGEAL that initiated events Due to (or as a consequence of) resulting in death) Last sician a burial-ARYNGEAL Physician/Medical CANCER phys nding pr IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) Month Year Pregnant at time of death o 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ LUNG METHSTASIC 1 DYes 2 No 3 Probably 4 Unknown Completed CHROMIC RESPIRATORY 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No Jas page 2 🗌 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending safter death.

I Director: Afferd in by the fur 2 No 2 Accident
3 Suicide
4 Homicide 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, sompleted filled in by determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number August 26, 2012 1018895 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KARIM, 7610 CARROLL AVESTE 340, TAKOMA PARIC, MD 20912 MOBARAK 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760°

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AUGUST MINNIE LILES 2012 7:40 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 246-90-9450 1 M 2 X F 61 NOV. 18, 1950 NORTH CAROLINA Usual Residence of Decedent 28a-f shov 10b. County the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND PRINCE GEORGE'S BLADENSBURG 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 4202 58TH AVENUE #307 20710 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ō ٥ 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify "natural", 3 Widowed 4 Divorced Completed **BLACK** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PHONE OPERATOR PRIVATE e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other r other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CLAYTON LILES ELMA ROBINSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau JAMES T. LILES / BROTHER 12809 SHOLTON STREET, UPPER MARLBORO, MD 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State RIVERDALE CREMATORY 8/30/2012 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MARYLAND 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enjer the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physiciani disease or condition Medical resulting in death) <sup>\*</sup>Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Ectopic pregnancy Month Day 5 Other (specify) detached 9 Unknown 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, cate has been sig ; page 2 should t Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No **Division of Vital** director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral of 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural injury To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certification 29d. Date signed (Month, Day, Year

State

AUG 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Willie Ralph Montgomery, Sr. Month 16:53 M August Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital BALTIMORE Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 260-32-5333 Days Director 1 M 2 □ F 83 10/20/1928 GA Usual Residence of Decede 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD **Baltimore** 129 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 2628 Guilford Ave. 21218 **USA** Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Dept Of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dave Montgomery Julia E. Chunn permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Ann Montgomery / Wife 2628 Guilford Ave., Baltimore, MD 21218 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Garrison Forest Veterans Cemetery 9/4/2012 Owings Mills, MD 4 Donation 5 Other (Specify) Signature of al Service 22. Name and Address of Facility MO155. Vaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 K 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Depsis WEEKS Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760A Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Pregnant at time of death Year 2 No 1 Yes 2 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 N 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 XNo 1 Yes Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 XNatural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) AT 2438 946 MM ss of person who completed cause of death (Item 23a) (Type, Print) IMANI 201 EAST UNIVERSITY YKWY , BALTIMORE, MA

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

AUG 28 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:35AM RGO LBR 2012 22 /Medical Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number) 4c. County of Death Examiner Ra Himore Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Social Seculity Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Min. 1 M 2 W F Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Kaltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ь pe items 23a must l by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) res 17. Father's Name (First, Middle, Last) Be 2 19a Informant's Name/Relationship (Type) State, Zin Code). 20b. Place of Dispo 20a. Method of Disposition 20c permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the shock, or hear disease, or complications that caused the death. Do not enter the ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTAT **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit attending physician and for use as the burial-tra P.O. Box 687666 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ned by the at detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performe 1□ Yes 2 21 NO within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö To the Hospital o within 24 hours aft Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) AUL 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar back

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8-26 Physician/ AM 6:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner County of Death Pircle 203 Hindon ind sor If Under Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 🗆 M 2 🗹 F **Director** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director nd501 1 Yes 2 No MOIR 10e, Street and Numbe 6 10g. Citizen of What Country? Be Completed by Funeral 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ဂ္ Informant's Name/Relationship (Type, Pr t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State emetery, crematory 4 ☐ Donation 5 ☐ Other (Specify) timore, Signature of Funeral Service Licensee laughn G. Greene Funeral Services 8728 1/5 town 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of sician and burial-transit Cause (Disease or iinjury that initiated events BREAST CANCER Due to (or as a consequence of): resulting in death) Last this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day 9 🗍 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISORDER ' 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' the Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No ပု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 100 29c. License number 29d. Date signed (Month, Day, Year) D22652 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. SURRAWANIAN SRINIVAS ETAILOCH BALTIMORE N.) 21239. 5001 LOCHRAVEN BLND Dr. SUBRAWANIAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

	AM	1EN	ID #27,28A	Plea -F, PEI	se Ty	<b>pe or</b> G930 State c	<b>Pri</b> i 87 of Ma	<b>nt in l</b> 24/1 arylan	<b>Black</b> 2 TR d / De	<b>Indelik</b> bartme	<b>ole Inl</b> nt of F	<b>k. Ens</b> Iealth	sure A and N	<b>III Copie</b> Mental Hy	es Are	e Leg	ible.		
			State Registrar			_			C	ertificat	te of L	Death			Reg. No	20	112	27	421
	Physicia	n/	Decedent's Name	, ,	,									Date of D     Month	eath Da	ay	Year	3. Time of	
James Land	Medic		Donna  4a. Facility Name (if	Delores		orat				4b City	, Town, or	Location	of Dooth	AUG		-	O12	3:40	PM
1	Examin	er	Good Sam				1001)				altin		or Death		40	c. County	or Death		
	Funeral		5. Social Security N		6. Sex	2 🛛 F	7. Age	e (In yrs. la	ast birthday		er 1 Year		r 24 Hrs.	8. Date of B	irth	· T	9. Birth	place (State o	r Foreign
	Director		219-80-6 Usual Residence of		1 L M	12121		5	O Yrs.	IVIOITIIIS	Days	Hours	IVIIII.	09/23	<u> </u>	1	Pen	nsylvar	nia
and	show	or	10a. State	10b. County				10c. City	y, Town or I	ocation							$\overline{}$	10d. Inside Cit	y Limits
Maryla	28a-f	rect	MD					Bal	ltimo	ce								1 🛭 Yes	2 🗆 No
the l	a or 2	al Di	10e. Street and Nun	nber							p Code				10g. C	itizen of V	Vhat Cou	intry?	
th wit	ns 23 must	Funeral Director	3608 Bay	onne Av							21206					U.S.			
r dea	or iter niner	by Fu	<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ied 2 Marri		Was Dece Armed Fo 1  Yes	rces?		S. 13	. Was Dece If Yes, spe	dent of Hi cify Cuba	ispanic O ın, Mexica	rigin? (Spe an, Puerto	cify Yes or No Rican, etc.)	)-		e - Ameri k, White,	can Indian, etc.	
<b>036</b> rs afte	ral", Exan	ed b	3 Widowed			If Yes, Giv Year or Da	e	IVO		1 🗌 Yes	2 🔀 No	Specify	y:			Specify:	Whi	te	
5-0	"natu	plet	(Spe	15. Deceden				- 3		edent's Usu e kind of wo			st of work	ina	16b. F	Kind of Bu	usiness Ir	ndustry	
# 22 ki	than	Com	Elementary/Seco		Ť	College (1		+)	life.	DÖ NOT us erver	e retired)	arnig me		9	Ī.	Food.	0 Dc	verage	
d 2 8	Hygie other ent, tl		17. Father's Name (I	First, Middle, La	ast)					er ver		18. Mot	her's Nam	e (First, Middle				verage	
/lan	Aenta urked tic ev	욘	Joseph	No]	lan							Hel	.en	Delore	25	Jone	S		
lan,	and N is ma auma		19a. Informant's Na	ame/Relationshi	ip (Type, F	Print)			19b. Ma	ling Addres	s (Street a	and Numb	er or Rura	l Route Numb	er, City o	r Town, S	tate, Zip	Code)	
2 . s pu	dealth		Ryan Mor		Son							Aveni		altimo					
Down Moratti Baltimore, Maryland 21215-0036	Department of Health and Mental Hygiene. Important; If item 22 is or 28a-f show Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 Burial 2	☐ Cremation		noval from	State	C	emetery, cr	oosition (Na ematory or	other plac			Date	1		-	own, State	
<b>Z</b> iff #	artme ortani injury		4 X Donation 21. Signature of Par					Ana		Sifts F				3/2012 natomy					
<b>B</b> and	Depar Impor any ir		1	1/										, Ste.				•	76
			23a. Part 1. Enter the shock, or hear	he disease, or o	complicati	ions that o	caused	the death	n. Do not e	iter the mod	de of dying	g, such as	s cardiac o	or respiratory a	ırrest,			Approximate	e veen
	ysician/		Immediate Cause ( disease or conditio	Final	.,	DIC												Onset and D	eath
	Medical caminer		resulting in death)	1	<b>r</b> -	32		consequ	,	) = A	15TZ	1201	16	ACII	2001	•		DAYS	
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executed	an and rial-transit	Examiner	Cause (Disease or i that initiated events	iinjury s	c					RAW	AL (	SEIZ	URE,	ASPI	RAT	TON		DAYS	
	± :5		resulting in death) L	_ast		Due to (	or as a	consequ	ence ot):				0	ICATION APPRO		EDICALE	XAMINER	ι	
760 760 icate t	s the t	ledic		`	d								CERT	ICATION APPRI	O PORTE		$\pm$		
ドルメール アルノビー ころふ アナ・エision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be	been signed by the attending physici should be detached for use as the bu		IF FEMALE: 23b. Was decedent			If yes, out				☐ Ectopic	pregnanc	v	J			23d. Dat	e of deliv	very	
Bo;	the att	/sici	in the past 12 n 1  Yes 2 9  Unknown	( No	1 -	4 ☐ Pregr 9 ☐ Unkn	nant at			Other (s						Moi	nth	Day Y	ear
at the	d by 1	ų.	Part II. Other signifi		s contrib	uting to de	eath bu	ut not resu	ulting in the	underlying	cause giv	en in Par	t I.	23e. Did	tobacco	use contr	ibute to t	he cause of de	eath?
Division of Vital Records, P.O.	signe d be	Completed by	CHRONIC	C ALC	OHC	LISM	1,	SEI	ZUR	E D	ISOK	DER	۷,					bably 4	
ord v requ	shou	Sete	TRAUMA				-						,	94 24a. Was	an	24b. V	Vere auto	psy findings a	vailable
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fall l	ctor, p	Be	25. Was case referre	ed to medical							7		ath (Check	only one)	ZAIN			2 🗀 110	
f Vit	this ce	၉	1 X Yes 2 2 27. Manner of Death		Hosp	<u> 1X</u>				ent 3 D		4 L N		me 5 🗆 Res				y)	
X O L	After funer	Certificate:	1 Natural	5 - Pending	-	28a. Date ( (Mont) 19 <b>99</b>	th, Day,	Year)	28b. Time injury UNK	M	28c. Injury work 1 🗆	rat ? Yes 2.∐		28d. Describe SUBJEC			ed		
Sio	ector:	ij	2 X Accident 3 Suicide 4 Homicide	6 Could n	ot be	8e. Place			ne, farm, s	reet, factor				_			r or Rura	l Route Numb	er, no 11
Div	all Dir				7,	UNKNO		(Specify)					ı	28f. Location ( City or To IKESVI	LLE,	<sup>"</sup> ₩3:	31	VILLAGI	E RUAI
Div	within 24 hours are death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 and 1.	Medical	(Check 2	Certifying I Medical Ex	aminer: (	On the basi	is of ex	amination	and/or inve	stigation, in	my opinio	n, death c	ccurred at	the time, date	and place	e, and due	to the ca	iuse(s) and mar	ner stated.
o the	omple		- 1		Nurse Pra	actioner:	To the b	est of my	knowledge		irred at the		e and plac	e, and due to t				tated.  Day, Year)	
			<ul><li>4</li></ul>	×/~	M	0					RES	oc	00						12
			30. Name and addre						23a) (Type		7 AL	. ,	2	) , B.		-/ > 4	0=	- 140	0100
	- 0.		EDMUN 31. Date filed (Month		+γ	PANA	_	<b>56</b> D 's Signati	1 LOC	HK	AVE	N 1	OLVI	13	ALI	11/14	KE	עוא ,	21239
	State Registra	_		AUG 2 8	2013		y still	o oignatt		back	1								

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State of Maryland / Department of Health and Mental Hygiene 20 | 2

Certificate of Death

Reg. No.

			For State Registrar	State of Maryland	Cen	tificate of D	Death	vicitairiy	Reg. No.	2012	21422
	Physicia	ın/	Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Day	Year	3. Time of Death
, Since May	Medic Examin		Joseph Cyril Ma 4a. Facility Name (if not institution, give stre			4b. City, Town, or	Location of Death		10.0	County of Death	1232AM
+ "	LXaiiii	CI	Carroll Hospital C				minster			Carroll	
	Funeral Director		5. Social Security Number 6. Sex 213-20-7831	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Birth	place (State or Foreign etry)
			Usual Residence of Decedent		6 Yrs.			Nov. 1	.6, 19	25 Mar	yland
	ryland I-f sho ied at	Director	10a. State 10b. County  MD Baltimo		Town or Loc					1	10d. Inside City Limits
	he Ma or 28a s notif		MD Baltimo	re	Balti	10f. Zip Code		Т	10a Citize	en of What Cour	1 Yes 2XXNo
	s 23a nust be	Funeral	8114 Duvall Avenue			2123	37		-	S.A.	
	r item			Was Decedent Ever in U.S. Armed Forces?	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14	1. Race - Americ Black, White,	
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4【XDivorced	1 ☐ Yes 2 <b>/</b> MNo If Yes, Give Year or Dates.	1	☐ Yes 2XXNo	Specify:		Sp	<sup>pecify:</sup> Whit	
15-0	2 hour "natu edical	Completed	15. Decedent's Educa (Specify only highest grade of	tion ompleted)	(Give ki	ent's Usual Occupa ind of work done de	ation uring most of work	ing	<del></del>	d of Business/In	
121	within 7 giene. er than , the M	Com	Elementary/Secondary (0-12)	College (1-4 or 5+)		NOT use retired) Machinist	-		Balt		Business
pu	filed wall Hygard A othe	Be	17. Father's Name (First, Middle, Last)			riaciiiiisi	18. Mother's Nam	ne (First, Middle,			
ylaı	nould be fil nd Mental marked matic ev	P.	Joseph Martinak				Mary H			_	
Mai	2 should lith and Me 27 is marl		19a. Informant's Name/Relationship (Type, Suzanne M. Fine (D			g Address (Street a Emory Rd.					Code)
re,	1 and of Hea item		20a. Method of Disposition	20h Pla	co of Dienos	ition /Namo of		D-4-		ation - City or To	own, State
Baltimore, Maryland 21215-0036	Page Iment o tant: If jury or		1 ☐ Burial 2 XX remation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State All	Faith & Cha	atory or other place s Cremato pel	5ry 8/28	3/2012			Maryland
Ball	permit. Page 1 and Department of Heal Important: If item 2 any injury or other	j	21. Signature of Fune I x rvice Licensee	5/	22.	Name and Address	s of Facility Ec	chardt E		_	
		Н	23a. Part / Enter the disease, or complica	ns that caused the death.		296 Charr the mode of dying				MD ZIIC	Approximate
A21-1-	Physician/		shook, or heart failure. List only one commendate Cause (Final disease or condition	ASUTE R	ESPH	RATOR	y FAL	LURE			Interval Between Onset and Death
مب	Medical Examiner		resulting in death)	Due to (or as a consequent of the to) (or as a consequent of t	nce of):	LIBRIT	- #=A	LUR	3.5		
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Dus to (u) as a consequer	ice city.	7		_		-	
	outed nd transit	Examine				CARDIC	myo	patt	17		
	hat the death certificate be executed ed by the attending physician and detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):						
8760	ficate to g physis	<b>dedical</b>	d								
39 ×	h certii tending	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnance		Ectopic pregnancy	/		230	d. Date of delive	
Вох	e deat the at thed fo	Physician/N	1 Ves 2 No	4 ☐ Pregnant at time of dea 9 ☐ Unknown	ath 5	Other (specify)				Month	Day Year
P.O.	that then the second point of the second sec	by Ph	Part II. Other significant conditions contril	outing to death but not result	ing in the un	derlying cause give	en in Part I.	23e. Did t	obacco use	contribute to the	ne cause of death?
ds,	requires that been signed I should be det	ted k						1 🗆	Yes 2 🗗	No 3 ☐ Prof	bably 4 🗆 Unknown
Division of Vital Records,	has be ge 2 sh	Completed						24a. Was auto	psy		psy findings available mpletion of cause of
Ä	iician: The la certificate ha rector, page		25. Was case referred to medical			26 Plo	ce of Death (Chec	1 \( \text{Yes}	2 No	1 🗆 Yes	2 🗆 No
Vita	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No	ital: 1 Inpatient 2 I EF	R/Outpatient	Other	_		dence 6 🗆	Other (Specify	)
οl	ing Ph		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of injury (Month, Day, Year)	Bb. Time of injury	28c. Injury work?	at	28d. Describe I			
Sior	Attend death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	e. farm. stree		res 2□ No	28f Location (	Street and N	Number or Rural	Route Number
Divi	tal or / rs after al Dire led in b		4 ☐ Homicide determined	building, etc. (Specify)	,			City or Tov		anno or or rarar	Troute Francis
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use	Medical	(Check 2 Medical Examiner:	n: To the best of my knowled On the basis of examination ar	nd/or investig	gation, in my opinior	n, death occurred a	t the time, date a	and place, an	nd due to the cau	use(s) and manner stated.
	To the Hosp within 24 hol To the Fune completely f		only one) 3 ☐ Certifying Nurse Pr 29b. Signature and title of certifier	actitioner: To the best of my	knowledge, o	29c. License	number			and manner as s signed (Month, L	
			1 200	ill-		- D3	026	3	8	7-25-	12
	(oV		30. Name and address of person who comp	eted cause of death (Item 23	Ba) (Type, Pri	int) PRIAL	AVE, W	ESTM	1050	ER /	no 2115
	Stat		31. Date filed (Month, Day, Year)	32. La gierrar's Signature							
	Registra		AUG 2.8 2012	1 A A	has	a Kend					

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			01-1-	partment of Health and Mental Hygiene ertificate of Death Reg. No. 2012 27423	}
	Physicia		1. Decedent's Name (First, Middle, Last)  Mary, Milton	2. Date of Death Month Day Year AVQUST 27 3. Time of Death 0258 M	_
5	Medic Examir		4a. Facility Name (if not institution, give street and number) Shock Trauma Center	4b. City, Town, or Location of Death  4c. County of Death	
	Funeral Director		5. Social Security Number  227-46-6617  Usual Residence of Decedent  6. Sex  1 □ M 2 ☒ F  7. Age (In yrs. last birthday 1 □ M 2 ☒ F	Nonths   Days   Hours   Min.   State of Birth (Month, Day, Year)   State of Foreign Country)   Nonths   Days   Hours   Min.   Aug. 26, 1937   Virginia	
	aryland a-f shov fied at	Funeral Director	10a. State 10b. County 10c. City, Town or I Maryland Baltimore Timoniu	is a more stylenomer and the sty	
	or 28s	Dig	Maryland Baltimore Timoniu  10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	$\dashv$
	h with ns 23a nust b	nera	3 Athenry Court Apt 301	21093 USA	
9000	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show er than "natural", the Medical Examiner must be notified at	þ	Armod Foreco	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ▼ No Specify:  14. Race - American Indian, Black, White, etc.  Specify: White	
21215-0036	withi giene er th er th	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4 or 5+)	edent's Usual Occupation  a kind of work done during most of working DO NOT use retired)  Listrative Coordinator  16b. Kind of Business/Industry  Community Health  Charities	
Maryland	e d fil	To Be	17. Father's Name (First, Middle, Last)  Richard Taylor Wilson	18. Mother's Name (First, Middle, Maiden Sumame)  Maude Wuanita Gray	
Mar	0 = 2 =			ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	1
re,	and deal		20a. Method of Disposition 20b. Place of Disposition	Belle Hollow Court; Glenwood, MD 21738  Date   20c. Location - City or Town, State	-
Baltimore,	. Page tment c tant: If jury or		4 Donation 5 Other (Specify) Bandy Co		
Bal	permit. Page 1 a Department of I Important: If its any injury or ot		21. Signature of Funeral Service Licensee  MOLO 50	22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228	
٠,	-	. v	23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory arrest, (\ \ \ \ \ \ \ \ Approximate	
	Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	- ( ) English	$\dashv$
	Examiner	-e	Sequentially list conditions, b. Fall	8 hrs	
K	uted d ansit	amin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O. W. R. ROWER	
Dr.	ate be executed hysician and the burial-transit	dical Examiner	that initiated events c. Due to (or as a consequence of):	Interval Between Onset and Death  Shr S  CERTIFICATION REPROPERTY WITH THE PROPERTY OF THE PRO	
3760	ficate b g physi as the l	Nedic	d		
. Box 687	the Hospital or Attending Physicians. The law requires that the death certificate be executed that A hours after death.  At A hours after death.  The Funeral Director. After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transi			☐ Ectopic pregnancy ☐ Other (specify)	
. P.O.	is that the gened by be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	1
ords	require been s	eted		1 Yes 2 No 3 Probably 4 Unknown	$\dashv$
Division of Vital Records,	he law ite has bage 2	Completed		24a. Was an autopsy prior to completion of cause of performed?	
tal F	Physician, The lav r this certificate has eral director, page 2		25. Was case referred to medical examiner?	1	
Ž	Physi this c ral dire	은	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of Death		_
o uc	inding ath. r: After re fune	icate	1 Natural 5 Pending  2 Accident Investigation 3 Sylicide 6 Could get be	work?	
VISIO	or Atte fiter de irecto in by ti	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital or Attending Physical within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral d		29a. Certiffer Secretifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and due to the cause(s) and manner as stated	44
5)	the Ho hin 24 I the Fu npletel	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inveonly one) 3 Certifying Nurse Practitioner: To the best of my knowledg	stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated e, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	1.
	5 vit		29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
	a		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 102739   August, 27,2012	-
	0		JULIA Slater, MD 22 South Greene.	Street, Baltimore, MD 21201	4
	Stat Registra			ale	
D. 11.					

# Baltimore, Maryland 21215-0036

09289	the Hospital or Attending Physician: The law requires that the death certificate be executed
Box	e death
P.O.	that the
Records,	The law requires
Division of Vital Records, P.O. Box 68760	tending Physician:
Divis	he Hospital or Attend
	ğ.

		For State	Plea	se Type o State			d / Depa	artmei	nt of H	lealth		All Copie Mental Hy		_	jible.	
Physicia	n/	Registrar  1. Decedent's Name  Virginia					Cer	tificat	e of L	eath		2. Date of D	Reg. Neath	ton U	1 <sup>2</sup> 2 <sup>ar</sup>	3. Time of Death 2: 35P M
Medic Examin		4a. Facility Name (if 3700 Ray	not institution,	give street and no	umber)				Town, or	Location	of Death	Aug.		c. County		
Funeral Director		5. Social Security No. 578–46–12	umber	6. Sex		e (In yrs. la	ast birthday) Yrs.		r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B	ay, Year,		9. Birthp Count	place (State or Foreign try)
yland -f show ed at		Usual Residence of 10a. State		merv		10c. City	y, Town or Loc					July 3	, 19	935	Chin	0d. Inside City Limits
ith the Mar 23a or 28a et be notifi	Funeral Director	10e. Street and Nun 3700 Ray	nber			Che	evy Cha	10f. Zij	Code				10g. (	Citizen of N	What Coun	1  Yes 2 X No
ter o	ě	11. Marital Status  1  Never Marri	ied 2 ☐ Marr	12. Was De Armed I	Forces?		If	Vas Decei Yes, spe	dent of His cify Cubar		n, Puerto	ecify Yes or No Rican, etc.)	-	14. Rac Blac	e - Americ ck, White, e	etc.
72 hours a in "natural" Medical Ex	Completed		15. Deceden	Year or t's Education st grade complete	Dates.		16a. Deced	ent's Usu	al Occupa			ing	16b.		Whit	
d within lygiene. ther tha nt, the l	as l	Elementary/Seco		4	(1-4 or 5	+)	Homer	_	,					vnhom		
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and 2 sho Health and em 27 is I		John McC  20a. Method of Disp	Cormick			20h D		oks F	ill i		#908	al Route Numb B Bethe	sda	, MD	20814	1
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permi Depar Impor any ir once.	4	21. Signature of Far 23a. Part 1. Enter ti	L. A		t causad	MO1	651 GG	oing ever	Home y L.	Hecl	nation crot		. C	P.O. larks	Box ville	e, MD 2102
Physician/ . Medical		shock, or hear Immediate Cause (I disease or conditio resulting in death)	t failure. List o Final	nly one cause on caus	each line. onic		tructiv						irest,			Approximate Interval Between Onset and Death
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be executed sician and burial-transit	al Examiner	Cause (Disease or i that initiated events resulting in death) L	injury	c. Due to	o (or as a	ı consequ	ence of):				_					· ·
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law requires that the death certificate be executed nas been signed by the attending physician and e 2 should be detached for use as the burial-transi	_	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 🔀 9 ☐ Unknown	nonths?		e Birth 2 egnant at	of pregnar 2  Fetal time of d	Ideath 3 🗌	Ectopic   Other (sp		,				23d. Dat Mo	e of delive	ery Day Year
requires that the dea been signed by the a should be detached t	۾	Part II. <b>Oth</b> er signifi	icant condition	ns contributing to	death bu	ut not resu	ulting in the ur	nderlying	cause give	en in Part	l.					e cause of death?
The law requate has been page 2 shou	Completed												psy ormed?	F	rior to con leath?	osy findings available inpletion of cause of
ysician; TI is certificat director, p	Be	25. Was case referre examiner?		Hospital:							th (Check	1 \(\sum \) Yes	2 🔀 1	No 1	Yes	2 LX No
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director, After this certificate I completely filled in by the funeral director, page	cate: To	1 ☐ Yes 2 🛭 27. Manner of Death 1 🛣 Natural 2 ☐ Accident		28a. Dat		у	ER/Outpatient 28b. Time of injury		8c. Injury work?	_4		me 5 🔀 Resi 28d. Describe				
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he Hospit iin 24 hour he Funera	Medical	(Check 2	Medical Ex	Physician: To the saminer: On the ba Nurse Practitions	asis of ex	amination	and/or investi-	gation, in	ny opinior	, death oc	curred at	the time, date.	and plac	e, and due	to the cau	se(s) and manner state
To t		29b. Signature and t	itle of certifier		~	7	<b>→</b>	290	License D3	number 7142				ate signed $8/24/$	(Month, D	ay, Year)
12/		30. Name and addre						,	ille	, MD	2085	50				
State Registra		<ol> <li>Date filed (Month)</li> </ol>	2 8 20	32.	Registrar	's Signatu	park	1								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph McKay August 27, 2012 Raymond 5:30A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oakland Manor Assisted Living Carrol1 Sykesville Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral Director** 578-34-2116 1 XM 2 □ F 07--19--1927 DC Usual Residence of Decedent 28a-f show must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll Sykesville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1473 Arrington Rd 21784 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner 14. Race - American Indian Black, White, etc. 2 1 Never Married 2 Married 1 Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Completed Specify: 3 ☐wWidowed 4 ☐ Divorced Year or Dates.WWII White permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Jonce. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Parts Business Owne**r** Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louise Loomis Raymond Mckay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Ryan (Daughter) 1473 Arrington rd, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) County Cremation 8/28/2012 Sykesville, MD ire of Funeral Service Licenses 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 MO1314 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive Airways Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Funeral Medical within 24 hor **To the Fune** completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 ARIQ MAHMOOD M.D. 19 RIDGE RD WESTMINSTER MD 21157

Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year) AUG 2 8 2012

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 2 27426 State of Maryland / Department of Health and Mental Hygiene

		1- For Stata Registrar	C	ertificate of D	eath	·	Reg. No.	
Physic Medical Exam		Decedent's Name (First, Middle, L     PATRICK MICHAE	·	•		2. Date of Dea Month August 2	ath	3. Time of Death 0026 hrs
		4a. Facility Name (if not institution, Peninsula Regional Med			City, Town, or Location Salisbury		4c. County of Death Wicomico	1
Funeral Director		212-92-0961 1	Sex 7. Age (In yrs	_	f Under 1 Year If Under Months Days Hours	N.C.	Foreig	thplace (State or on unty/land
Maryland 28a-f show any d at once.	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltim		ity, Town or Location				10d. Inside City Limits 1 Yes 2 XX No
with the Maryland ms 23a or 28a-f she be omtified at once	Director	10e. Street and Number  12318 Cleghorn A	venue_		21030	1	10g. Citizen of What Cour	ntry?
fter death I", or ite	by Funeral		1 Yes 2XX No ed If Yes, Give Year or Dates:	If Yes,	ecedent of Hispanic Orig specify Cuban, Mexican s 2 XX No specify:	, Puerto Rican, etc.)	White, etc.	can Indian, Black, White
36 in 72	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade completed)  College (1-4 or 5+)		Jsual Dccupation (Give of working life. DD NOT	kind of work done use retired)	16b. Kind of Business/li	ŕ
21215-0036 hould be filed within 7 nd Mental Hygiene. is marked rither than	Be	17. Father's Name (First, Middle, La John Charles McC	usker		Jo	's Name (First, Middle, I yce Tweedle	•	
, MD 2 and 2 shoul ealth and M tem 27 is m	P <sub>C</sub>	19a. Informant's Name/Relationship  Jacqueline Falte  20a. Method of Disposition	r McCusker Wif	19b. Mailing Ad  e 12318 C  D. Place of Disposition	eghorn Ave	nber or Rural Route Nun  NUE COCKEYS  Date	nber, City or Town, State, Sville, Mary	land 21030
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental. Important: If item 27 is marked injury or other traumatic event,		1 XXBurial 2 Cremation 3 4 7 Donation 5 Other Special Service Lice	Removal from State	laney Valley	Mem Grdns	08/29/2012	Primonium,	Maryland
Physician	- /	23a. Parl I. Enter the disease, or confailure. List only one cause or	CALLACIA  Applications that caused the dea	6500	York Road	Baltimore,	Maryland 2	1212 Approximate Interval
/Medical Examiner			a. Multiple Injuries  Due to (or as a consequence	of):				Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence					
760, cate be executed physician and the burial - transit		events resulting in death) Last	Due to (or as a consequence tAMENDED	of):				
Box 68760, death certificate be exche attending physician of for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	23c. If yes, outcome of pre 1 Live birth 4 Pregnant at time of c	2 Fetal de	eath 3 Ectopic	pregnancy	23d. Date of delivery Month Da	ay Year
P,O.	Ā	Part II. Other significant conditions	contributing to death but not	resulting in the under	lying cause given in Par		bacco use contribute to the 2 No 3 Proba	
of Vital Records, ng Physician: The law require. There this certificate has been st meral director, page 2 should b	Completed	25. Was case referred to medical			26.Place of Death (	autops perfor 1 ✓ Yes 2	sy prior to co med? death?	mpletion of cause of
on of Vita iding Physicia h. After this cer e funeral direct	To Be		Hospital: 1 Inpatient 2 V  28a. Date of Injury (Month, Day Year) Aug 24, 2012	ER/Outpatient 3 28b. Time of Injury 2038 hrs	IOther:	Nursing Home 5 I	Residence 6 Other:	
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investiga 3 Suicide 6 Could no determine	t be 28e. Place of Injury - At I			. 28f. Location (S or Town, St	treet and Number or Rura ate) and Coastal Highway, (	
To the Hosy within 24 ho To the Func completely f	edical	one) 2 Medical Examina	cian: To the best of my knowled r:On the basis of examination and manner stated.	dge, death occurred a and/or investigation, i	n my opinion, death occ	ce, and due to the cause urred at the time, date a	e(s) and manner as stated and place, and due to the	i. cause(s)
04 m		29b. Signature and title of certifier  30. Name and address of person who	completed cause of death (Iter	m 23a)	29c. License number O.C.M.E.		29d. Date signed (Month	h, Day,Year)
σ' \'	ate	31. Date filed (Month, Day, Year)	ssistant Medical Exami		Itimore Street, Ba	Itimore, MD 21223	3	
Regist	rar	AUG 2 8 2012	and A A	ORIGINAL				
OCHE 2000		COME		URIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ AUSUS CHARLES EDWARD McMANUS. JR. Medical 01 4a. Facility Name (if not institution, give street and number) Examiner JOSEPH MEdiCAL Social Security Number 7. Age (In yrs, last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 140-07-0312 Hours Director 1 X M 2 □ F 98 June 4, 1914 New York Usual Residence of Deceder er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Marvland Baltimore County Towson 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road , #734 21204 **IJSA** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Crown, Cork and Seal Executive Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Edward McManus Eva Mina Olt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Eva McManus Edmonds (Daughter) 19603 Spring Creek Road, Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dul. Valley Mem Grdns 8/28/2012 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signal of Entral Service Consession Martin D. Lawson MITCHELL WIEDEFELD FUNERAL HOME 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Divi to for as a consequence of Exami law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? ≦ Division of Vital Records, 2 X No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate Yes 2 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 잍 1 Nopatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending of Funeral Director: Af eletely filled in by the fu Accident
Suicide
Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hor To the Funer completely fil 29a. Certifier (Check only one SLER DRIVE AUG 2 8 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month resolun 11:54 AM 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 1701 Brookview Road Dundalk Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 1)
April 23, 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗶 F Days 217-40-4933 Months Director 69 Yrs Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Md. Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1701 Brookview Road 21222 USA items 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 KNo If Yes, Give Year or Dates 1 Yes 2 XNo Specify: White than "natural", Completed 3 Widowed 4x Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Guard Security Service 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental. Important: If item 27 is marked c any injuy or other traumatic eve once. ဂ Charles Seymour Caroline Rasel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Myers Daughter 1701 Brookview Road, Dundalk, Md. 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 30 1 Burial 2 Cremation 3 Removal from State Bayview Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Diset and Death Physician/ cerdiom disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery Live Birth 2 L retail 352.

Pregnant at time of death in the past 12 month Month Day Year the g Unknown g 🗌 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has leampleted filled in by the funeral director, page 2 seconpleted filled in by the funeral director, page 2 seconpleted filled in by the funeral director, page 2 seconpleted filled in by the funeral director. autopsy Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 10 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending iniury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WW and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

28

7566

Registrar's Signature

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Ach Saltinure

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8, Date of Birth **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 🗆 F 84 Months Days Hours 06/02/1928 215-24**-**7806 Director Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Perry Hall 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? pe Funeral "natural", or items 23a 9904 Fox Hill Rd 21128 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Rlack. White, etc. Completed by 1 Never Married 2 Married If Yes, Give 1950-52 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 Divorced and Mental Hygiene.

is marked other than "natur raumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12College (1-4 or 5+) Steel Mill Security Guard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances J. Leitkowski .. Page 1 and 2 should be f tment of Health and Menta tant: If item 27 is marked jury or other traumatic e Frederick D. Marjenhoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9904 Fox Hill Rd. Perry Hall, Kirk M. Marjenhoff- Son MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Altantic Crematory or other place 8/27/2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Rd. Nottingham, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) archaomo inkacron Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a conse, unnount s been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2 1 No after death.

Director: After this certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manyer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury ▼ Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar S

31. Date filed (Month, Day,

00%

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

34359 (0410)

Boulevard, Baltimore

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ August 22 2ď12 12:15 AM Daniel Joseph Mackell, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Collingswood Nursing Center Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours Min. (Month, Day, Year) 170-20-3428 Director 1 🕅 M 2 🗆 F January 9, 1927 85 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 ☐ Yes 2 🔀 No Virginia Henrico Richmond 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 23229 United States 203 Walsing Drive death 12. Was Decedent Ever in U.S.
Armed Forces?
1 \( \bar{\text{L}} \) Yes 2 \( \bar{\text{No}} \) No
If Yes, Give 194 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1944-Black, White, etc. ŏ ٥ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 X Widowed 4 ☐ Divorced 1946 White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) State Department 5+ Foreign Service Officer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F မ Page 1 and 2 should be Monica Costello Daniel J. Mackell and s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 l: Thomas P. Mackell / Son 203 Walsing Drive, Richmond, Virginia 23229 20a. Method of Disposition 20b. Place of Disposition (Name of Montgomery Crematory or other place) Crematorium, Inc. 20c. Location - City or Town, State Date Department of I Important: If its any Injury or of once. 24, 1 Burial 2 Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01305 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Poset and Death Immediate Cause (Final Ischemic Cardiomyopathy Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicia e Funeral Director. After this certificate has been signed by the attending physicial eletely filled in by the funeral director, page 2 should be detached for use as the bundled the strategy filled in the funeral director. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death Yes 2 No 1 Yes 2 q Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig ; page 2 should b 2 🕅 No 3 🗆 Probably 4 🗆 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 🔼 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Hospital: 1 ☐ Yes 2 🕅 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending iniury 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38262 August 24, 2012 161 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9043 Shady Grove Court, Gaithersburg, Maryland 20877 Anurita Mendhiratta, M.D. AUG 2 8 2012 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

White Davidson Minton, Jr. State of Maryland / Department of Health and Mental Hygiene 2012 27431 1- For State Certificate of Death Rea No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death Month Day August 23, 2012 Medical Examiner 1225 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5076 Orville Avenue Baltimore **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min 1 X M 2 F Country) Unh Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.

ant: If item 27 is marked atther than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. ural", or items 23a or 28a-f sho miner must be notified at once. ltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 Funeral Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 Yes 4 Divorced If Yes, Give Year Vietnam Yes 2 No specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) triciar 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ephew Cow! 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify. 22. Name and Address of Facility Green 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial - tran sician/Medical UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No 25. Was case referred to medical 26 Place of Death (Check only one) æ Hospital: Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Inpatient ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: A 1 V Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Homicide 29a. Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 24, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day Year) Registrar

OCME

### State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 08 Alfred 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Delmont Road Severn Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) Days Hours Director 212-54-9286 1 🛛 M 2 🗆 F 08/23/1950 28a-f shov permit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location Director Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1277 21144 Delmont Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married β 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 9 General Contractor Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mervel E. Miller Lillian E. Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1277 Delmont Road, Mrs. Patricia R. Miller / wife Severn, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 08/27/2012 | Ellicott City, Maryland John's Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD M01357 Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Example 1. Example 2. The shock, or how 1 failure. List only one cause on each line. Immediate Cause (Final JUNS hot 1elourd Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burlal-transit The law requires that the daath certificate ba executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month signed by the aid be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tUnknown Completed . Were autopsy findings available prior to completion of cause of page 2 autopsy ☐ Yes 2 No 25. Was case referred to medical of Vital 26. Place of Death (Check only one) 8 examiner? 1 \( \overline{A}\) Yes 2 \( \overline{A}\) No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred UNK M 1 Natural 2 Accident 5 Pending MIMSEIS 221 1 Yes 2 No Investigation 6 Could not be 152 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10:30 AM

Birthplace (State or Foreign Country)

White

21144

Onset and Death

Day

1 ☐ Yes 2 ☐ No

MD

10d. Inside City Limits

1 Yes 2XXNo

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Division

Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated )eour 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Jones 5 mo

32. Registrar's Signature

tome

State Registrar 29a. Certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 Month GEORGE NICHOLSON Physician/ WILLIAM 9:15 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. (Month, Day, Year) Director 511-03-9965 1 🖾 M 2 🗆 F Yrs. 95 December 23,1916 Kansas Usual Residence of Deceden or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21044 U.S.A. 5349 Woodnote Lane hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. 1 Ves 2 No If Yes, Give 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 Divorced Navy Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Flight Dispatcher TWA Airlines 12 should be filed wi lith and Menta! Hygie 27 is marked other r traumatic event, <u>ti</u> Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, ల Bessie Blanche Blood Frank A. Nicholson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Jane Holcomb (Daughter) 5349 Woodnote Lane Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 📝 Removal from State ò Department of Important: If any injury or 9-5-2012 Greenwood Cemetery Wichita, Kansas 4 Donation 5 Other (Specify) 21. Signature of Function Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc. 40123 5555 Twin Knolls Road Columbia, Maryland 21044 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE HEART FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DISEASE CHRONIC OBSTRUCTIVE PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of). physician and as the burial-transit CONGESTIVE HEART FAILURE Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical PULMONARY HYPERTENSION Box 68760 attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? Yes 2 N 1 ☐ Yes 2 ☐ No or Attending Physician: **Division of Vital** 25. Was case referred to medical funeral director, 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ဥ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After to in by the funeral Certificate: (Month, Day, Year) 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

5755 Cedar Lane

who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Columbia, MD 21044

29d. Date siggled (Month, Day, Year)

3 Certifying Narse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 2355 1clin-e Medical 4a. Facility Name (C) ot institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death けい Ma DAMOYE 7. Age (In yrs. last birthday) 85 Yrs. If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 M 2 M F Country) **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Ves 2 No 0 10e. 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral "natural", or items Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Back 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last ည ta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing, Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Kaltimore JUSIN permit. Page 1 and 2 Department of Health Important: If item 2: 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dat 1 Burial 2 Cremation 3 Removal from State Dumie 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and A dress of Facility CKO HI MUYE 23a. Part 1. Enter the diseast, or complications that caused the death. Do not enter the orde of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ mometrial Cancel disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached Unknown P.O. Part II. <mark>Other significant conditio</mark>ns contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 certificate 1 Yes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t 1 Natural 5 Pending Division 1 Yes 2 No Accident Investigation Suicide Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 91213205 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOT Breche Baltimore,

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) AUG 2 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aus POREMCK! **Physician** /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Riverview Nursing Center Essex Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 11, 1954 7. Age (In vrs. last birthday) 6. Sex Months Hours **Funeral** Days MD 1 🔀 M 2 🗆 F 58 216-74-7270 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantiner must be inclined at 1 ☐Yes 2€ No Essex Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21221 USA 320 Savannah Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ MNo 11. Marital Status Black, White, etc. 1X Never Married 2 Married White 1 ☐Yes 2XNo Specify. Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) disabled disabled 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maritana A. Koch Alphonse Poremski ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 320 Savannah Road Balto. MD 21221 /mdther Maritana A. Poremski Item 27 I 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of permit. Pages 1 al Department of Her Important: If Item any injury or othe once. 20a. Method of Disposition Baltimore MD 8/28/12 Oak Lawn Cemetery 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 300 Mace Ave. Balto. MD 22. Name and Address of Facility 21. Signature of Funeral Service Little see Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1 Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final ReB Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Year 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown o. 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? ۵. ne underlying cause given in Part I. Part II. Other significant conditions contributing to death but not resulting in of Vital Records, Completed by 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has performe 2 □ No 2 7 1 ☐ Yes 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes 2 □ No Certification: To this 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death After Division or Attending 1 Natural
2 Accident 5 Pending investigation Aug S 2012 10 28e. lace of Injury - At home, building, etc. (Specify) 1 ☐ Yes 2 🐼 🗎 on own me, farm, street, factory, office death. ocation (Street and Number or Rural Route Number, City or Town, State) 330 Squarence (Secondary) after death. 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hours a To the Funeral L To the Hospital 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

1

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar 2012 27436 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month August ,2012 Wilbur Preston, Jr. 7:10 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. Director 215-18-6631 1 X M 2 □ F 90 May 29, 1922 Maryland Usual Residence of Decedent Show 10a. State 10b, County or then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at with the Maryland 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1055 W. Joppa Road Apt 251 21204 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Manital Status 14. Race - American Indian, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is merked other then Elementary/Secondary (0-12) College (1-4 or 5+) Attor<u>ne</u>y Law treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Wilbur D. Preston, Sr. Erlich Rena 1 and 2 should b of Health and Mer item 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204Wife 1055 W. Joppa Road Apt. 251 Towson, Maryland Lucinda W. Preston Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of I Importent: If Ite any Injury or of once. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. 8-28-2012 Towson Marvland Suna of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ Aspiration Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner mont Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ ğ in the past 12 months? Month Day 2 🗆 No Year signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ been signated Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy performed this certificate Yes 2 X director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 LOther (Specify) Wo SNU 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c\_License number 29d. Date signed (Month. Day, Year) 5X of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

AUG 28

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Ma	ryland		artment of H		and M		giene Reg. No.	2012	2	274	. 37
		Registrar  1. Decedent's Name (First, Middle, Last)		<u> </u>	incate of t	Jealii		2. Date of De		_ 0 1 2		3, Time of I	
Physicia		Loretta Reitz Peterson						August		201		4:15	
Medic Examin		4a. Facility Name (if not institution, give street and number)			4b. City, Town, o	r Location o			1	County of De			
		Charlestown Care Center			Catons	ville	:			timor			
Funeral			(In yrs. las		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birl		9. B	sirthplac	ce (State or	Foreign
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ind <b>show</b> at	5		10c. City,	Town or Loc	cation		·				10d	. Inside Cit	y Limits
lanyla Ba-f s tified	Director	Maryland Baltimore	Ce	atonsv	ille							1 🗆 Yes	2 🛛 No
the N or 2	<u> </u>	10e. Street and Number			10f. Zip Code				10g. Citize	en of What C	Country Country	?	
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Maryland 21215-0036 12 should be filed within 72 hours after lith and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	Be	17. Father's Name (First, Middle, Last)				18. Mothe	er's Name	First, Middle,	Maiden Su	rname)			
ylai	ပ	John Reitz				Hil	da Ka	ufman					
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e, P and 2 Healtl em 2: ther t		Joan Peterson Daughter  20a. Method of Disposition	OOL DI		elvin Av	enue;							
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State	cen	netery, crem	sition (Name of natory or other place			ate		ation - City o			
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on C arth. : Afte	cate	1 → Natural 5 □ Pending (Month, Ďay, 1 2 □ Accident Investigation	Year)	injury	work			d. Describe II	ow injury o	courted			
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thin 2 thin 2 the ?	Me	only one) 3 Certifying Nurse Practioner: To the be 29b. Signature and title of certifier	st of my k	nowledge, d	eath occurred at the	e time, <b>d</b> ate	and place,	and due to the	e cause(s) a	nd manner a	as stated	d.	
5 ½ 년 8			2		ROS		2_	I		signed (Mon 2 <del>7</del> – 1		Year)	
		30. Name and address of person who completed cause of dea		3a) (Time D					6 ~	- 7 - 1			
10		Ann Butterworth, CRUP 7	109 V	Maidu	nche, ce	(one	_ Ba	lto. W	ld a	1122	8		
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Registra	ar	AUG 28 2012 Com	. A.	ha	Kel								

DHMH 17 Rev 7/2009

12-06384 John M. Peifer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

JOHN W. Pellel		1- For State Registrar	Certificate o	of Health and Mental of Death	, ,	eg. No. 201	2 2743		
Physic Medical Exan					Date of Deal     Month     August 24	Day Year	3. Time of Death		
		4a. Facility Name (if not institution, give street and number	)	4b. City, Town, or Location of Dea		4c. County of Death			
		5579 Spectrum Drive  5. Social Security Number 6. Sex 7. Ac	- (laura la	Frederick		Frederick			
Funera Directo		216-72-1441 <sub>1</sub> K <sub>M 2</sub> <sub>F</sub>	ge (In yrs. last birthday) 55 Yr		lin. Dec.1	th(MM/DD/YYYY) 9. Bin Foreig Con			
any		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Loca	ation			10d. Inside City Limits		
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ith the Maryland 23a or 28a-f sho	Director	10e. Street and Number 11218 Baker Road		10f. Zip Code 21757	10	og. Citizen of What Cour USA	itry?		
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral		?   If \	as Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	White, etc.			
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5-0036 led within 72 hours a Hygiene. other than "natura the Medical Exami	Completed	2	Posta	al Clerk		US Postal Service			
21 be fi	Be	17. Father's Name (First, Middle, Last)  Jack Harold Peifer		18.Mother's Name (First, Middle, Maiden Surname)  Mary Eileen Hardy					
O g B is #	욘	19a. Informant's Name/Relationship (Type, Print)  Tessie M. Peifer / wife		g Address (Street and Number of 8 Baker Rd. Keym			Zip Code)		
ore, MI ss 1 and 2 s of Health a Vitem 27		20a. Method of Disposition	20b. Place of Dispos	sition (Name of cemetery,	Date	20c. Location - City or	Town, State		
Pages nent of ant: It or othe		1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify:	Final Jou	rney Crematory 8	3/29/12	Woodbine,	MD		
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Funeral Service Licensee	M01651 PA	Name and Address of Eccilemat	ion Serv	ice P.O. Bo	x784		
Physician		23a. Part I. Enter the disease, or complications that caused	the death. Do not enter to	everly L. Heckro	or respiratory arre-	et shock or heart	Approximate Interval		
/Medical Examiner			ne, Lamotri	gine, Zolpidem)	arug tox	cicity	Between Onset and Death		
berr		or condition resulting in death)  Due to (or as a consessed provided in the conditions, b.	equence of):						
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Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	unpended	,27,28a-f,pe	er me,g931 9-14-	12 sm				
760 ficate b g physic the bun	/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the				23d. Date of delivery			
Ox 68760, eath certificate be exe attending physician of our use as the burial	ician/	past 12 months?	time of death	tal death 3Ectopic pregr her (S <i>pecify</i> )	ancy	Month Da	y Year		
D. Bc t the dea by the a ached fo	Physic	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death	but not resulting in the I	ınderlying cause given in Part I.	23e Did tob	acco use contribute to the	o onuse of death?		
P.C. rres that signed be deta	by		but not resulting in the u	inderlying cause given in Fart I.		2 ✓ No 3 Proba			
ords v requi s been should	olete				24a. Was an		psy findings available mpletion of cause of		
Records,  The law require ficate has been si	Completed				perform	ned? death?	2 No		
ital fincian: s certifi rector,	Be	25. Was case referred to medical examiner? [Hospital:		26.Place of Death (Check					
of Vital  1g Physician  After this certi	.: To	1 Yes 2 No Inspired Inpatier  27. Manner of Death  1 Noticed (Month, Day, Ye			28d. Describe ho	esidence 6 🗹 Other:	Scene		
ion ttendir death. ttor: A	atior	2 Accident Pending Investigation Fd 8-24-	-12 fd 12:2	3 pm 1 Yes 2 X No	subject a plastic	ingested di bag over h	ugs and put is head		
Division pital or Attendi ours after death.	Certification:	3 X Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, stree	et, factory, office building, etc.	28f. Location (Str or Town, Sta	reet and Number or Rura	Route Number, City		
Hospi 24 hou Funer tely fil		4 Homicide determined (Specify) Hot ( 29a. Certifier 1 Certifying Physician: To the best of my		red at the time, date and place, and	rrederic	K,MD.			
To the Ho within 24 P To the Fu	Medical	one) 2 Medical Examiner: On the basis of exam and manner stated.	nination and/or investigati	ion, in my opinion, death occurred	at the time, date an	nd place, and due to the	cause(s)		
	~	29b. Signature and title of certifier	A	29c. License number O.C.M.E.		29d. Date signed <i>(Montl</i> August 25, 2012	n, Day,Year)		
(10)	ł	30. Name and address of person who completed cause of de				-5			
				altimore Street, Baltimore,	MD 21223				
Si Regis		31. Date filed (Month, Day, Year) 32. Redistrar		wed					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per Fil 6931 and 2962012 refl of Health and Mental Hygiene

			For State Registrar		State-of	Marytan	•	tificate of		and iv	-	giene Reg. No.2	012	271.20
			Decedent's Name	(First, Middle, I	.ast)						2. Date of De	ath	UIZ	3. Time of Death
	Physicia Medic		Harold I	Edward (	)uann						Aug. 2	3, Day	2012 Year	6:19A <sup>M</sup>
	Examin		4a. Facility Name (if	not institution, g	ive street and number	r)		4b. City, Town, o	r Location	of Death		4c. C	ounty of Deat	th
- mark			6125 Ove					Bethes					ntgome:	ry
	Funeral Director		5. Social Security Nu			Age (In yrs. la		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)	Co	thplace (State or Foreign untry)
			096-18-32 Usual Residence o		1 🔀 M 2 □ F	87	Yrs.				Oct.1	$\frac{3}{4}$ , $\frac{192}{192}$	24 Ne	w York
	land show	ģ	10a. State	10b. County			y, Town or Loc							10d. Inside City Limits
	Mary 28a-1	Director	MD	Montgon	ery	Be	thesda							1 ☐ Yes 2X No
	th the	ョ	10e. Street and Num					10f. Zip Code				10g. Citizen of What Country?  USA		
	th wil	Funeral	6125 Ove	rlea Roa				2081						
	or ite		<ol> <li>Marital Status</li> <li>Never Marrie</li> </ol>	ad 2 12 Marria	12. Was Decede Armed Force 1 1 1 Yes 2	s?		Vas Decedent of F Yes, specify Cub	lispanic Or an, Mexica	igin? (Spe n, Puerto I	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.		
98	safte rei",	핥	3 Widowed		If Yes, Give Year or Dates		<b>1</b> 5 1	☐ Yes 2X No	Specify	:		Sp	ite	
5-0	within 72 hours after death with the Maryland glene. er than "naturel", or items 23e or 28a-f sho er than "naturel", or items 23e or 28a-f sho ite Medical Exercited must be notified at	Completed by	(Spec	15. Decedent's		1742	16a. Deced	ent's Usual Occup	ation		- 7		of Business/	
2	hin 72 ne. than '	E	Elementary/Seco		College (1-4	or 5+)	life. DO	NOT use retired,						
4	ed witi Hygier other t	0	17. Father's Name (F	imt Middle Lor	5+		Commu	nication	r					ications
and	be filed lental Hy rked oth ic event	힏	Richard (		<i>y</i>				i		(First, Middle, McCar		name)	
<u>Z</u>	should and Me is mar	Н	19a. Informant's Na		(Type, Print)		10h Mailin	q Address (Street			_		Ctata Zi	- Co-dol
ž	J2sh altha 27is		Jane Quar					Overlea						i code)
ğ.	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hyglene.  If Item 27 is marked other than "naturel", or items 23e or 28a-f show or other traumatic event, it a Medical Examination must be notified at		20a. Method of Disp			20b. P	lace of Dispos	sition (Name of latory or other pla	- :		ate		ation - City or	Town, State
Ĕ	Page nent ant: It	Ш	1 ☐ Burial 2 2 4 ☐ Donation		☐ Removal from Sta cify)		-	ney Crem		8/2	7/12	Wood	bine, 1	MD
Baltimore, Maryland 21215-0036	permit. Page 1. Department of I Important: If it eny injury or of		21. Signature	eral Service Lice	ensee		22	Name and Addre	as of Casili					x 784 le, MD21029
		$\mathbf{H}$	23a Part 1 Enter th	a disease or or	mplications that cau	M01							rksvil	
			shock, or hear	t failure. List only	one cause on each	line.	i. Do not ente	r the mode of dyli	ig, such as	cardiac o	r respiratory an	rest,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)		a	odyspl as a consequ							$\rightarrow$	2YRS
فمرسدا	Examiner			. (	Due to (or a	as a consequ	ierice or).							
		ner	Sequentially list cor if any, leading to im-	mediate	b. Due to (or	as a consequ	ence of):							
	outed nd ransit	am	cause (Disease or in that initiated events	injury	c								3	
	e exection and unital-1		resulting in death) L	ast	Due to (or	as a consequ	ence of):							
200	icate be executed g physician and is the burial-transit	ledical Examin		•	d									
687	ertific ding p se as		IF FEMALE:		23c. If yes, outcor	ne of pregnar	ncv							
P.O. Box 68	requires that the death certific been signed by the attending should be detached for use as	Physician/N	23b. Was decedent p in the past 12 m	nonths?	1  Live Birt	h 2 🗌 Feta	I death 3	Ectopic pregnant	СУ			23	<ul> <li>d. Date of del Month</li> </ul>	livery Day Year
ω.	the de y the ached	hysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	INO	9 🗌 Unknow			(9000)/						
<u> </u>	that the ned be determined by	by P	Part II. Other signific	cant conditions	contributing to deat	h but not resu	ulting in the ur	nderlying cause gi	ven in Part	l.	23e. Did to	obacco use	contribute to	the cause of death?
ds,	quires en sig ould b	pe									1 🗆	Yes 2 🙀	No 3 ☐ Pr	robably 4 🗆 Unknown
Sor	as be	ple									24a. Was		24b. Were auf	topsy findings available completion of cause of
E.	The l	Completed					_				perfo	rmed?	death?	s 2 □ No
ta	cian: ertific ector,	Be	25. Was case referre examiner?		Hospital:				ace of Dea	th (Check	only one)			
<u>&gt;</u>	Physi this c	은	1 Yes 2 2 27. Manner of Death	No	1 ☐ Inp		ER/Outpatient 28b. Time of		4 ∐ N		ne 5 🔀 Resid			ify)
0	ding th. After fune	Certificate:	1 ☑ Natural 2 ☐ Accident	5 Pending	(Month, i	Day, Year)	injury	28c. Injur worl M 1 □	yat ⊲? Yes 2.⊑		8d. Describe h	ow injury o	curred	
Sio	Atten r dear sctor: by the	ŧ	3 Suicide 4 Homicide	Investigat 6 Could not determine	be 200 Place of	Injury - At hor	me, farm, stre	et, factory, office	163 2		P8f. Location (S	Street and N	lumber or Rui	ral Route Number,
Division of Vital Records,	al or s afte i Dire	3	4 LI Homicide	determine		etc. (Specify)		, ,			City or Tow		ambor or ridi	a rosto rumbor,
_	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	29a. Certifier 1 (Check 2	Certifying Pl	nysician: To the best	of my knowle	edge, death o	ccurred at the tim	e, date and	l place, an	d due to the ca	ause(s) and	manner as st	ated. cause(s) and manner stated.
	the Ithe Ithe Ithe Ithe Ithe Ithe Ithe I	Me	only one) 3	☐ Certifying N	urse Praguitioner: To	the best of m	y knowledge,	death occurred at	he time, da	te and place	ce, and due to t	he cause(s)	and manner as	s stated.
	ე <b>ა</b> ≰ <b>ა</b>		29b. Signature and ti	tie of oertifier				29c. Licens MD76!				29d. Date s 8/24	igned (Month	n, Day, Year)
	121		6)	/ Vin	w							٥, ۵		
	1,3x,		30. Name and addre							2000	7 6			
	Stat	e	31. Date filed (Month	, Day, Year)	1, M.D. 2'	strar's Signati	ure		ı, DC	2003	/_Suite	2 707		
	Registra		Al	UG 282	012 Deter	u &	. pa	Ke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

8/28/2012 JH
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Auq. William B. Rau Jr. 25 20<sup>Year</sup>2 5:30A Medical **Examiner** 4a. Facility Name (if not institution, give street and number. 4b. City, Town, or Location of Death 4c. County of Death Transitions Healthcare Sykesville Carroll . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Min Director 216-28-8406 1 M 2 D F 82 Usual Residence of Decedent 05/31/1930 MD or 28a-f show In than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Carroll 1 Yes 2 No Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 112 Elaine Avenue 21157 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married 1 Yes 2 No Black, White, etc. \$ Maryland 21215-0036 other than "natural", 1 Yes 2 No Specify: Specify:White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mail Carrier Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of William B. Rau Sr. Bertie Feidler ige 1 and 2 should be nt of Health and Men t: If item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian A. Rau-wife 112 Elaine Ave., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of I Date cemetery, crematory or other place ŏ 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Westminster Cem 8/29/12 any injury Westminster 21. Signature of Turn al Service Licensee 22. Name and Address of FacilityFletcher Funeral & Cremation 254 E. Main St. Westminster, MD 21157 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) dranov Medical Due to (or as Examiner Sequentially list conditions, if any leading to immediate Examine if any leading to immedicause. Enter Underlying equence of) Cause (Disease or injury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Nnknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed after death.

Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death Check only one) Hospital: 1 🗌 Yes 2 🗆 🗷 1 Inpatient 2 ER/Outpatient 3 DOA lursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation 1 Yes 2 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature a V0050165 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ernesto Mendoza, JR 5263 Grovemont Drive Elkridge, MD 21075 31. Date filed (Month, Day, Year, Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PI LINE A-D, PER ME C930 8/24/12/ TRT

The State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0030M Month Year **Physician** Bernice RobINSON June 09 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Months Days 217-66-5607 55 25/ Director 1957 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryk Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. MD N/ADirector Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2617 Edison Hwy. 21213 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph V. Robinson Elizabeth Oliver ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn White-Sister 2020 Linden Ave. Baltimore, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 6/19/2012 OwingsMills, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 21. Signature of Fuheral Service Licensee 22. Name and Address of Facility  $ext{March}\ ext{F/H-East}$ 1101 E. North Ave. Baltimore, 21202 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. **COMPLICATIONS OF**Immediate Cause (Final disease or condition Approximate Interval Between cardiac or respiratory atrest AND CARDIOVASCULAR Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical or as a correquence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed VOS that initiated events VEICATION APROVED BY MEDICAL EXAM attending physician and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 687605 Physician/Medical tox tome a 24a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed? 2 No 2 🗌 No 25. Was case referred to medical examiner? or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: in 24 hours after deau... he Funeral Director. After this ce unletely filled in by the funeral dire 1 Ves 2 □ No 1 Inpatient 2 FR/Outpatient 3 DOA 5 Residence ည 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H72353 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JHBMC 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) State Registrar AUG 28 201

Kendrick Lamont Richardson 12-06036 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2012 27442 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ August 12, Day 0728 hrs Medical Examiner Kendrick L. Richardson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4331 Route 2 Edgewater Anne Arundel 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Min oreian Director 577-19-8436 Country) 37 03/31/1975 1 X M 2 F DC Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a State 10b County 1 Yes 2 No 28a-f show DC Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. DC Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1912 18th Street, United States S.E 20020 Funeral 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Never Married 2 2 X No Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed Specify: Black à 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) d other than Baltimore, MD 21215-0036 None None 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas D. Richardson, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7716 Chesterfield Ct. White Plains MD. Douglas D. Richardson, Jr t: If item? 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/23/12 Waldorf. Heritage Cemetery 4 Donation 5 Other Spg 22. Name and Address of Facility 21. Signature of Funeral Servi McLaughlin Funeral 2518 Penn Ave. SE Washington DC 20020 Approximate Interval ons that caused the death, Dr not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ਾਕਾत ।. Enter the disease, or failure. List only one caute Physician 23a, Part I. Enter the disease Between Onset and **Wicaica** Death Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FFMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the a be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>6</u> 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been director, page 2 should 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene DOA this 1 Yes 2 No 28a. Date of Injury FOUND: (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27 Manner of Death Certification: Pedestrian struck by auto 1 Natural FOUND: 1 Yes 2 ✔ No 5 Pending Director: Aug 11, 2012 0721 hrs 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) 4331 Route 2, Edgewater, MD determined To the Funeral I 4 Homicide (Specify) Major Road / Highway 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E August 13, 2012 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

ORIGINAL

32 Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ling Li, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Year Physician/ 10:15 A M Aug. Doris Anna Brown Rigby Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Wilson Healthcare Center Gaithersburg 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🛛 F July 10, 1916 Massachusetts 96 Director 149-30-1705 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County with the Maryland Examiner must be notified at Director 1 🔀 Yes 2 🗌 No Gaithersburg MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number ò USA Funeral 20877 ga 301 Russell Ave. items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 9 Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Healthcare Registered Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Anna Kaesemodel Isadore J. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 Potecasi Creek Court Hertford, NC 27944 David Rigby / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Final Journey Crematory 8/29/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, M . Signature of Funeral Service Licensee M01651 21029 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician/ Vicano disease or condition resulting in death) Medical Examiner /ear Sequentially list conditions. Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No signed by the atte 5 Other (specify) Pregnant at time of death 9 Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? 24 hours after death.

2 Funeral Director. After this certificate has less than the sector, page 2 ? 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: Nursing Home 5 Residence 6 Other (Specify) မ 1 Tyes ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director, of completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature title of certifie

Registrar

State

30. Name and ada

31. Date filed (Month Day)

ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Aug. Physician/ 2012 23. 0720 Barbara Marian Raff Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Spring Montgomery Silver If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 89 Director 040-46-3526 1 M 2 XF Yrs. Aug. 10,1923 England 10d. Inside City Limits iral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 1 ☐ Yes 2X No Chevy Chase MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United Kingdom 20815 8100 Connecticut Ave. #1705 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Matlida Sutton Frederick Edwin McKenzie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 Friendship Street Newport, RI 02840 Christiane Raff / step-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 8/24/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Emeral Service Licensee Going Home Cremation Service, P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Cerebrovascular Accident Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and I for use as the burial-transi The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☒No Month Day Year Pregnant at time of death signed by the at Id be detached for a 🗌 Hinknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Hypertension 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has be autopsy performed? 1 ☐ Yes 2 🔀 No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 1 Yes 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title Aug. 23, 2012 D63579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Maria J. Tauag,

**AUG 28** 

31. Date filed (Month, Day, Year)

MD

1500 Forest Glen Rd. Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death August Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Seasons Hospice at Northwest Randallstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 219-32-3394 1 X M 2 □ F 79 WI 1933 Aug 6 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count Director 1 Yes 2 No MD Carroll Eldersburg 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 21784 USA 6502 Ridenour Way Apt 1C Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. 1 Never Married 2 M Married 2 Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☐XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) insurance salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Benjamin Hamilton Roche Minniebell McFadden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6502 Ridenour Way Apt 1C, Eldersburg, MD 21784 19a. Informant's Name/Relationship (Type, Print) Mrs. Barbara Roche (spouse) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any Injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-28-12 Eldersburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Para Saight erbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Enq-Stage Dementia Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar NS RAJAPALSE MD 2835
31. Date filed (Month, Day, Year)

AUG 2 8 2012

nslegapahlmo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Smith N

5203

DO057465

Baltimore

MD

24/12

21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of D		Mental Hygi	ene g. No 201	2 27446
ì	Physicia	ın/	1. Decedent's Name (First, Middle, L	,				2. Date of Death	1	3. Time of Death
-	Medic Examin	cal	JOHN JOS 4a. Facility Name (if not institution, gi	EPH ve street and number)	RITKO	4b. City, Town, or	Location of Death	AUGUST	22,20 T	
d			1229 KENDRICK  5. Social Security Number 6.			RO	SEDALE  If Under 24 Hrs.	Long (Bin		ALTIMORE
	Funeral Director		170-26-6413 Usual Residence of Decedent	Sex 7. Age 1 ■ 7. Age	e (In yrs. last birthday) 82 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 1)	Year)	Birthplace (State or Foreign Country) ENNSYLVANIA
	aryland a-f show ified at	Director	10a. State 10b. County	TIMORE	10c. City, Town or Lo		SEDALE			10d. Inside City Limits 1 ☐ Yes 2X No
	vithin 72 hours after death with the Maryland jiene. •r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	eral Dir	10e. Street and Number 1229 KENDRICK	ROAD		10f. Zip Code	21237	10	ng. Citizen of What	
	death v items ner mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		rmerican Indian, /hite, etc.
9000	irs after iral", or I Exami	ed by	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2	947-50	1 ☐ Yes 2 🕱 No	Specify:		Specify:	WHITE
21215-0036	72 hou n "natu Medica	Completed	15. Decedent's (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done o O NOT use retired)		ting 1	6b. Kind of Busine	ess/Industry
212	d within ygiene. her thai it, the N	Be Cor	Elementary/Secondary (0-12)	College (1-4 or 5	+1	UPERVIS				EHAM STEEL
Maryland	ould be filed water Hyg marked othe matic event,	To B	17. Father's Name (First, Middle, Last MIKE	RITE	KO .		18. Mother's Nam	ne (First, Middle, Ma	aiden Surname) MISE	K
	shi han 7 is trau		19a. Informant's Name/Relationship CATHERINE RITK			ng Address (Street a			City or Town, State, ALE, MD	
nore	Page 1 and 2 ment of Healt ant: If item 2 iry or other:		20a. Method of Disposition  1  Burial 2 X Cremation 3 4  Donation 5  Other (Spe		1	osition (Name of matory or other place CREMATOR			20c. Location - City	or Town, State
Baltimore,	permit. Page Department of Important: If any injury or once,		21. Signature of Funeral Service Lice		22		ss of Facility CV	ACH/ROS		UNERAL HOME
	الملك		23a. Part 1. Enter the disease, or co shock, or heart failure. List only	mplications that caused one cause on each line	the death. Do not ent					Approximate
~[	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ong	consequence of):	(Krial	)CCLUSI	met	leg	diset and Death
- E	Examiner	)r	Sequentially list conditions,	5WG	e period	wal V	esaela	rdisea	ise o	10 years
	uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of):	letes				20460B
09	ate be executed ohysician and the burial-transit	dical E	resulting in death) Last	Due to or as a	a consequence of):					
		/Med	IF FEMALE:	23c. If yes, outcome	of programmy					
. Box 687	that the death certifica ed by the attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		2 Fetal death 3	Ctopic pregnance Other (specify)	y		23d. Date of Month	delivery Day Year
ds, P.O.	law requires that the nas been signed by tl e 2 should be detach	by	Part II. Other significant conditions		at not resulting in the control of t	underlying cause giv	en in Part I.			e to the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law rec cate has bee page 2 sho	Completed						24a. Was an autopsy perform	prior deat	e autopsy findings available to completion of cause of h? Yes 2 L No
ital	ysician: The law is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Otho	ace of Death (Chec	k only one)		
ν of V	ding Phys h. After this funeral di	ate: To	27. Mann r of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day		f 28c. Injury work	4 ☐ Nursing He	ome 5 X Resider 28d. Describe how		pecify)
ivisio	al or Attences after death	Certificate:	2 ☐ Accident Investigati 3 ☐ Suiçide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Inju	ry - At home, farm, str . (Specify)		Tes 2 🗆 NO	28f. Location (Stre City or Town,		Rural Route Number,
į,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check 2 L Medical Exa	nysician: To the best of miner: On the basis of ex	kamination and/or inves	tigation, in my opinic	n, death occurred a	t the time, date and	place, and due to t	he cause(s) and manner stated.
2	To the within To th∉	Σ	29b. Signature and title of certifier	Quitor	M)	29c. License			d. Date signed (Mo	
	04/ Re	0.1	30. Name and address of person who	gompleted cause of de	eath (Item 23a) (Type, I	Print)	0017		-0/01	7114
	Stat	HE .	31. Date filed (Month, 10), Year AUG 282	3 Maratra	r's Signature	. 4.1				
	Registra	z.U	HUU 4 0 40	114 Centre	I PU. JURIA	V-C-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HELEN MARIE ROBY AUGUST 2012 :29A M 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1230 HESSE AVENUE ROSEDALE BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 5-24-1924 216-14-8286 MARYLAND Director 1 🗆 M 2 🖾 F 88 Yrs Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1230 HESSE AVENUE 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. 1 Never Married 2 X Married ğ 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced WHITE Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ALEXANDER** ZALENSKI JOSEPHINE BANASHAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT L. ROBY, SR./HUSBAND 1230 HESSE AVENUE ROSEDALE, 21237 MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 8-28-12 CATONSVILLE, MD 21. Signature of Funeral Servi 22. Name and Address of FacilityCVACH / ROSEDALE FUNERAL HOME ROSEDALE, MD 1211 CHESACO AVE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burlal-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certifica letely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 1 🗆 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28b. Time of 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and a death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		į	_ State	te of Maryland / Dep	oartment of Fertificate of D			2012	27448
			Registrar  1. Decedent's Name (First, Middle, Last)		eruncate or L	<i>Jeann</i>	Re-	g. No UIC	3. Time of Death
_	Physicia Medic		Sylvia Jean	Richards		<u> </u>		2f, 2012 ear	4:18 P M
	Examin	er	4a. Facility Name (if not institution, give street an Sinai Hospital of Bo	· ·	4b. City, Town, or Baltimo	Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birth	9 Birth	place (State or Foreign
	Director		236-54-6045 1 □ M 2 f		Months Days	Hours Min.	(Month, Day, Y Feb. 14,	1938 West	try) Virginia
Б	now at		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				
arylan	a-fsh fied a	Funeral Director	MD 1337 333M	Baltimor					10d. Inside City Limits  1X☐ Yes 2 ☐ No
he M	or 28 noti	吉	10e. Street and Number	Daitimor	10f. Zip Code		1 10	g. Citizen of What Cou	
with 1	23a ust be	eral	939 Regina Drive		21227			USA	
death	items ier m		11. Marital Status 12. Was	Decedent Ever in U.S. 13 ed Forces?	. Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race - Americ	can Indian,
36 after o	", or camin	ğ	1 L Never Married 2 X Married 1 L	Yes 2 X No s, Give	If Yes, specify Cuba		Rican, etc.)	Black, White, Specify: Whi	
	atural cal Ex	Completed	3 Widowed 4 Divorced Year  15. Decedent's Education	or Dates.					
215 172 h	an "n Medi	mpl	(Specify only highest grade comp	leted) (Give	edent's Usual Occupa e kind of work done d DO NOT use retired)		<i>n</i> g 1	6b. Kind of Business In	dustry
within	giene er tha , the		Elementary/Seconday (0-12) Colle	ege (1-4 or 5+)	omemaker		C	wn Home	
nd filed	tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma	,	
<b>S</b> Pa	Men narke	۲	William J. Pettrey					ns Pettrey	
Baltimore, Maryland 21215-0036  Dermit. Page 1 and 2 should be filed within 72 hours after	nt of Health and Mental Hygiene.  t: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	N	19a. Informant's Name/Relationship (Type, Prifet) Billie Eugene Richard		lling Address (Street a			ity or Town, State, Zip (	Code)
<b>1</b> and	f Heal item other		20a. Method of Disposition	20b. Place of Disp	position (Name of			Oc. Location - City or To	own. State
mo Page	unt: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	- I OIII OLULO	ematory or other place n Mausoleu	e) [	- 1	Princeton,	
	Department of Important: If ite any injury or of once.		21. Sign ture of Fureral Service Licens		22. Name and Addres			an Funeral	
<b>D</b> 80	<u> </u>		Laure settle	in !	5517 Vine				310
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	on each line.		g, such as cardiac o	r respiratory arrest	,	Approximate Interval Between
	sician Medical	i	Immediate Cause (Final disease or condition resulting in death)	The state of the s	No I	FORCT			Onset and Death
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		iner	Sequentially list conditions, if any Lading Limbouries in Drawse. Enter Underlying	to forms a consequence of.	n				Jews
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<b>56</b> /	nding Ise as	M/		s, outcome of pregnancy	_			23d. Date of deliv	001
death of	atter d for u	icia	in the past 12 months?		☐ Ectopic pregnance ☐ Other (specify)	У		Month	Day Year
that the	by the	Physician/Med	9 ☐ Unknown	Unknown					
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<b>Ž</b> 🚆	ficate r, pag		25. Was case referred to medical				performe 1 Ves 2		2 🗆 No
/ICa siciai	certi	o Be	examiner? Hospital:	1 Minpatient 2 ☐ ER/Outpatie	1.50	ice of Death <i>(Check</i> r:			
OT O	er this	e: To	27. Manner of Death 28a.	Date of injury 28b. Time of	of 28c. Injury	at 2	me 5 □ Residend 28d. Describe how	ce_6  Other (Specify injury occurred	)
on andin	or; Aft	ficat	2 Accident Investigation	(Month, Day, Year) injury	M 1 🗆	Yes 2 No			
DIVISION tal or Attendin	in by t	Certificate:		Place of Injury - At home, farm, stouilding, etc. (Specify)	treet, factory, office		28f. Location (Stree	et and Number or Rural State)	Route Number,
spital	eral C		29a. Certifier 1 Certifying Physician: To	the best of my knowledge, death	occured at the time	date and place are	d due to the squae	(a) and manner as state	
DIVISION OF VITAL RECORDS, P.O. BOX 68/0 To the Hospital or Attending Physician: The law requires that the death certifical	within 24 nous after beaut.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check 2   Medical Examiner: On the	ne basis of examination and/or inve inegy To the best of my knowledge,	stigation, in my opinio	<ul> <li>death occurred at</li> </ul>	the time, date and i	place, and due to the car	use(s) and manner stated
To th	To tl		29b. Signature and title of certifier	110	29c, License	number	290	I. Date signed (Month,	
	M				WAS 1	8760		Huy 29,	2012
[	3 8		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print)	8260 wn MD	LILIX		
	Stat	e		32. Signature	Z VU TIV	THE THE	- 10 10		
JUMU 1	Registra	ar	AUG 2 8 2012	Dur S. A	and				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 08 2012 11:00 AM Noelie Maria Roman Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Magnolia Center Lanham Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day Year) 15 Country) Mississippi Months Days 1 D M 2 X F Min Director 96 Yrs 084-12-6815 Usual Residence of Decedent 28a-f shov 10b. County 10a. State notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Prince George's Landover 10e Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 7427 Village Green Terrace 20785 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. ğ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dietician Food Service 6 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pete Thomas Adele Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francisco A. Roman / Son 14824 Pepper Tree Drive, Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 8/23/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ dverce disease or condition resulting in death) 2051 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause E to orderly g Cause (Disease or linjury Due to (or as a consequence of): and -transit Exam that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician sthe burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ Pregnant at time of death Day Year ed by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 🗀 No 2 🗓 Yes 1 Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) 2 110 မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending □ Accident
□ Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined

Box 68760 P.O. Records, To the Hospital or Attending Physician: Division of Vital

Baltimore, Maryland 21215-0036

after death.

Director: Aft
d in by the fur within 24 hours after de
To the Funeral Directo
completed filled in by th

State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Luch Ra. & 300 wordso. 2114 NO 31. Date filed-(Month, Day, Year)

32. Registrar's Sanature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month RIDEOUT JANNARD 1420 M 20112 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N BALTIMORE INIVERSITY OF MARYLAND MED CENTER Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 214-82-161 Months **Director** 1 🗆 M 2 🖼 United Hygiene. other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No nary land DORG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 United State 0 21869 Route Old 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 Never Married 2 Married þ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Waller traumatic 19a. Informant's Name/Relationship (Type, Print) permit, Page 1 and 2 st.
Department of Health an.
Important: If item 27 is re any injury or other Rural Route Number, City or Town, State, Zip Code) Wall Bulton 21212 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) U.M. Cherch Com 21, Signat o Funeral Service Licensee 22 Name and Address of Facility 3512 EVERELLIAMS alvin MO21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** MOSCESS INTRAPODOLINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and DIVERTICULTITS the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ signed by the atte d be detached for in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by END STAGE REMAL DOSEASE 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor Yes 2X No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 22

Hen Baron, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NFI 1942576921

SCUTTH GREENE ST

AUGUST 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012

		1	For State Registrar	State of Ma	aryland		artment of F tificate of L		and M		giene Reg. N	2111	2 27	1451
Physic	cian/ dical	/	1. Decedent's Name (First, Middle, La HENRY	SEARBUI	ROUG	カナ				2. Date of De Month	ath 23	ay Yea		e of Death 2019 M
Exam			4a. Facility Name (if not institution, giv	ŕ			4b. City, Town, or			,	40	c. County of De	eath	
Funan			Catonsville Co.  5. Social Security Number 6.3	mmons	(In vrs la	st birthday)	If Under 1 Year	onsv		8. Date of Birl	th		Ltimore Birthplace (Sta	
Funer: Directo	_			1 <b>X</b> M 2 □ F	87		Months Days	Hours	Min.	(Month, Da	y, Year)		Country)	_
D wo	Π.		Usual Residence of Decedent  10a. State 10b. County							Aug. 18	,19	143 Mi	aryland	
ıryland a-f sh	ا و		,	imore	Tue. City,	Town or Lo		aton	svill	۵				e City Limits Yes 2 X No
ne Ma or 28a notif	اً ا	5	10e. Street and Number	HIOLE			10f. Zip Code	Jacon	DATT	.e	10a C	itizen of What		163 2 /4 140
with t	Funeral Director		16 Fusting Ave	nue				2122	.8		10910	United		S
death items			11. Marital Status	12. Was Decedent E Armed Forces?		1	Vas Decedent of Hi f Yes, specify Cuba	ispanic Ori	igin? (Spec	cify Yes or No-		14. Race - Ar Black, Wh	nerican Indian	,
after after xamil	Ž		1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 X Yes 2 1 If Yes, Give	№ 194 194	<b>∔3</b> −  ,	☐ Yes 2 🏋 No			. ,			white	
5-0C hours	Completed		15. Decedent's	Year or Dates. Education	194	16a. Deced	lent's Usual Occup	ation			16b. l	Kind of Busines	ss/Industry	
215 lin 72 le. han ",		=	(Specify only highest g Elementary/Secondary (0-12)	rade completed)  College (1-4 or 5	+)	life. D	kind of work done of NOT use retired)	duning mos	st of workin	g				
d with	Re C		9			Never	Worked					/A		
and be file ental H ked o	15		17. Father's Name (First, Middle, Last)  George Scarbore						er's Name garet	(First, Middle, Muel]		i Surname)		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam			19a. Informant's Name/Relationship (	Type, Print)	_		ng Address (Street a	and Numb	er or Rural	Route Numbe	r, City o			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at			James Andrews / 1	Friend		828 I	rederick	Rd.,	Cato	onsvill	Le,	Marylar	nd 2122	28
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other		1	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 [	Removal from State	ce	metery, cren	sition (Name of natory or other plac			ate		_ocation - City		
Itin ii. Pa artmer artmant injury	انه	-	4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Licer			ro Cre	ematory I	nc.	08/24	/2012   Nabb E		ltimore		
Department of the state of the	ouce	-	2. Signature of Aboutin	TE CON	layı		01 Freder							
		1	23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplication that caused one cause on each line	the death								Approxi	
Physician	_		Immediate Cause (Final disease or condition	ATHEROS	CLEF	2011C	CERER	3Res V	ASCO	CLAR	D	ISEASE		nd Death
Medica Examine			resulting in death)	Due to (or as a	. conseque	ence of):								
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760 icate be executed I physician and Is the burial-transit	edical			d										
certifi certifi anding use as	N S		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			15					23d. Date of o	delivery	
Box death ne atte	Physician/M		in the past 12 months? 1 ☐ Yes 2 ☐ No	1			Ectopic pregnanc Other (specify)					Month	Day	Year
Ivision of Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi.			g ☐ Unknown  Part II. Other significant conditiens		ıt not resu	lting in the u	nderlying cause giv	en in Part	1	23e Did to	hacco	use contribute	to the cause	of death?
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ord v requ	lete									24a. Was			autopsy findin	
<b>Rec</b> The law the has bage 2	o mo									autor perfo 1 \(\sum \) Yes	rmed?	death	completion?	at cause of
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F VIII Physic this or all dire	유	2	1 Yes 2 No 27. Man of Death	Hospital: 1  Inpatie		R/Outpatier 28b. Time of	ot 3 DOA Othe	N LIAN				6 ☐ Other (Sp	ecify)	
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Division of Vital Records, lal or Attending Physician: The law requires is after death.  In Director: After this certificate has been signed in by the funeral director, page 2 should be to be	Certificate:		3 Suicide 6 Could not 4 Homicide determined	oe 280 Place of Injur		ne, farm, stre	eet, factory, office		2	8f. Location (S		nd Number or F	Rural Route No	ımber,
Div pital or ours aft eral Dir filled in									//					
To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical		(Check 2 Medical Exan	/sician: To the best of r niner: On the basis of ex rse Practitioner: To the	amination	and/or invest	igation, in my opinio	on, death o	ccurred at t	he time, date a	and place	e, and due to th	e cause(s) and	manner stated
To the within To the	2		only one) 3 $\square$ Certifying Nu 29b. Signature and title of certifier	rse Practitioner: 10 the	best of m	y knowledge,	29c. License		не апо ріас	e, and due to t		ate signed (Moi		
			Jasneen	Lachan	£ 6	mi)	Da	2886	35		8/2	4/12		
311			30. Name and address of person who		eath (Item 2	23a) (Type, P	orint)	s- C	Dwir	NG-S	Mi	u mi	2111	}_
S <sup>c</sup> Regis	tate trar		31. Date filed (Month, Day, Year) AUG 28 20	112 32 Registra	r's Signatu		whol							
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DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. 101	artment of Health and Mental Hygiene tificate of Death  Reg. No. 2 1 1 2 2 7 4 5 2
			Registrar  1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici /Medic		Anthony Surai	August 25 ZOIZ 2:59 AM
	Examin		4a. Facility Name of not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
7			Johns Hopkins Bayview Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year
	Funeral Director		216-16-2404 1 1 1 1 M 2   F   88 Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year)   9. Birthplace (State or Foreign Country)   9. Birthplace (State or Foreign Co
			Usual Residence of Decedent	
	farylan fshow	ō	10a. State   10b. County   10c. City, Town or Lo	iddle River
	r 28a-	Director	10e. Street and Number	10f. Zip-Code 10g. Citizen of What Country?
	death with the Marylams 23a or 28a-f sho ms 23a or 28a-f sho must be notified at	alD	10012 Crane Lane	21220 USA
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces  1 □ Never Married 2 ☒ Married  1 □ Yes 2 ☒ Mo	Was Decedent of Hispanic Origin? (Specify Yes or No- f Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
036	ours af	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Yes 2 No Specify: Specify: White
5-0	72 ho 'natur dical I	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation Kind of work done during most of working DO NOT use retired)
121	within ene. than '	dmo		Rollmaster Accounting
d 2	e filed I Hygid other ent, th	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Malden Surname)
Vlar	ould be Menta arked artic ev	To E	Agatino Sgroi	Sophia Tagliavia
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner		19a. Informant's Name/Relationship (Type. Print)   19b. Mailli   Louise G. Sgroi /wife   1	ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0012 Crane Lane Baltimore MD 21220
ē,	s 1 and of Health Item 27 other tr		20a. Method of Disposition 20b. Place of Dispo	sition (Name of Date 20c. Location - City or Town, State
imo	Pages ment of tant: If It		4 Bonation 3 Other (Specify)	valley 8/29/12 Baltimore MD
Balt	Departit Depart Import any Inj once.		21. Signature of Funeral Service Licensee  Lours Teles Compelly N	Connelly Funeral Home of Essex 21221
			23a. Part 1. Efter the disease, of complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a.   C. R.M. NE 4.477  Due to (or as a consequence of):	VE BACTEREMIA SEPSIS
ef	Examiner			,
	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
11/2	be executed cian and burial-transit	Examiner	Cause (Disease or injury that initiated events c Due to (or as a consequence of):	
760, N	ate be exi	dical E	d d	
387	ifficate g physias the	e e	<u> </u>	
×	eath certifica attending ph d for use as t	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy  23d. Date of delivery  Month Day Year
P.O. Box 68	hat the death cert d by the attending detached for use	Physician/M	1   Yes 2   No 4   Pregnant at time of death 5   9   Unknown 9   Unknown	Other (specify)
P.	that the	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds	w requires that been signed is should be de	ed b	Abdominal Aochi Aneury	1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
eco	ne law requ has been ge 2 shou	Completed	End-stage renal disease	24a. Was an autopsy prior to completion of cause of death?
<u> </u>	The cate had			1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No
Zit.	sician: The certificate irector, pa	Be	25. Was case referred to medical examiner?  1 — Yes 2 No Hospital: 1 Dinpatient 2 — ER/Outpatier	26. Place of Death (Check only one)  tt 3 □ DOA Other: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)
Division of Vital Records,	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	on: To		f 28c. Injury at 28d. Describe how injury occurred Work?
risic	ttendi death. stor: A y the f	ficati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, str	M 1 ☐ Yes 2 ☐ No  Set, factory, office 28f. Location (Street and Number or Rural Route Number,
Ö	al or A s after il Direction bed in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or Town, State)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 <b>YCertifying Physician:</b> To the best of my knowledge, deat	n occurred at the time, date and place, and due to the cause(s) and manner as stated.  vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
_	To the vithin To the comp	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			11-6-	1407113616 August, 25, 2012
	10		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 4940 Eastern Avenue, Baltimore, MD, 21224
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
	Regist	rar	AUG 28 2012 Prema D. Barks	

DHMH 17 Rev 1/2001 11595

12-06339 Richard Dennis S		1- For State	r <b>Print in Blac</b> of Maryland / D	<b>k Indelible I</b> Department o Certificate o	f Health ar	re All Cop nd Mental I	<b>ies Are L</b> Hygiene	20	12 2745
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)		Och timodic o	Douti		2. Date of D		3. Time of Death
Medical Examin	ier	Richard Dennis Sauter 4a. Facility Name (if not institution, give			Ab Oite Terre	1		22, 2012 Year	1410 hrs
Į.		50 Winters Lane	street and number)		4b. City, Town, or Catonsville		เก	4c. County of Baltimore	
Funeral Director		5. Social Securify Number 6. Sex 1 1 1	, ,	yrs. last birthday) 50	If Under 1 Yes Months Day		_	. 1	Birthplace (State or Foreign MD Country)
gue	F	Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Locat	tion				10d. Inside City Limits
≱ .]	<u>_</u>	MD Baltimore		Catonsville					1 Yes 2 XXNo
Maryla 28a-f d at or	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
ith the Maryland 23a or 28a-f show notified at once.		50 Winters Lane			21228			USA	
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces?	If Y	as Decedent of His es, specify Cubar	spanic Origin? ( 5 n, Mexican, Puert	Specify Yes or I o Rican, etc.)	No- 14. Race - A White, e	American Indian, Black, etc.
after d	by Fr	3 Widowed 4 XXDivorced	or Dates:	1	Yes 2xX No	specify:		Specify: V	/hite
hours natur		15. Decedent's Education (Specify only	highest grade complet	ted) 16a. Deceder during m	nt's Usual Occupa nost of working life	tion (Give kind of . DO NOT use re	work done tired)	16b. Kind of Busir	ness/Industry
336 thin 72 re. than edical	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	W	elder			cs	SX
		17. Father's Name (First, Middle, Last)				18.Mother's Nam	e (First, Middle	, Maiden Surname)	
2121 Ild be f Mental narke event,	To Be	Robert Sauter 19a. Informant's Name/Relationship (Typ	e Print )	19h Mailine	Address (Street	Beverly	/ McHugh	umber, City or Town,	00-1- 77- 0-1-1
MD 2 shouth and P 27 is n	-	Michael Sauter	Brother	127	Starhill L	ane, Cator	nsville,	MD 21228	State, Zip Code)
re, re f Healt f Healt f f Healt f f item		20a. Method of Disposition  1 Burial 2 Y Cremation 3		20b. Place of Dispos crematory or oth		metery,	Date	20c. Location - C	ity or Town, State
imo Page ment o tant:		4 Donation 5 Other Specify:		Bayview Cr	ematory	_	27, 2012	Baltimor	e, MD
Balt permit Depart Impor		21. Signature of Funeral Service License	~ /	22. N	lame and Address Fink Funer	of Facility a Home, F	P.A.		
Physician	+	23a. Rart I. Enter the disease, or complic	MO1148 ations that caused the	death. Do not enter th	426 Crain he mode of dying,	such as cardiac	or respiratory a	nie, MD 2106 rrest, shock, or heart	Approximate Interval
/Medical Examiner		failure. List only bone cause on each Immediate Cause (Final disease a.A.	cute Alcoho	1 Intoxic	ation				Between Onset and Death
7		or condition resulting in death)	e to (or as a conseque		-				
	ē	Sequentially list conditions, b  f any, leading to immediate Du	e to (or as a conseque	nce of):		-			
	ĒΙ	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e to (or as a conseque	nce of):		<del></del> -		-	
executed an and al - transit	- 1	d							
O, s be exertised and burial -	rnysician/medical		AMENDED 23a, p		8a-f,per	me,g931	9-14-1	2 sm	
1876 rtificate ing phy as the	2	F FEMALE: 3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth		tal death 3	Ectopic pregn	ancy	23d. Date of de Month	livery Day Year
OX 6	SICI	1 Yes 2 No 9 Unknown	Pregnant at time  Unknown	of death	ner (Specify)				,
Division of Vital Records, P.O. Box 68760, and or Attending Physician: The law requires that the death certificate be executed reads.  **I Director: After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transitification: To Bo Completed by Direction and artification:		Part II. Other significant conditions	entributing to death but	not resulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use contribut	te to the cause of death?
res that signed I be det	D D	Hypertension; Di	abetes Mel	litus			1 Ye	es 2 No 3	Probably 4 Unknown
ords w requ	Completed						24a. Was		re autopsy findings available r to completion of cause of
Rec The la icate ha	5						perf 1 <b>✓</b> Yes	ormed? dea 2 No 1 ✓	th? Yes 2 No
ician:	B   '	5. Was case referred to medical examiner?	pital:	500		of Death (Check		1	
of Vi	2   2	1 Yes 2 No 7. Manner of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of In	0011	y at Work?	ng Home 5 28d. Describe	Residence 6 🗸 (	)ther: Scene
ion tendin eath. for: A the fur		1 Natural 5 Pending 2 X Accident Investigation	(Month, Day, Year) <b>fd 8–22–12</b>	2 fd 2:00	1 Y	es 2 🗶 No	subject	consumed	alcoho1
Division o  Division o  spital or Attending  filled in by the fune		Suicide 6 Could not be	28e. Place of Injury -	At home, farm, stree	t, factory, office bu	uilding, etc.	28f. Location or Town.	(Street and Number of State) 50 Wint	or Rural Route Number, City
fospita F hours uneral		4 Homicide determined  9a. Certifier 1 Certifying Physician	(Specify) Fd:Re		and at the time			State) 50 Wint wille, MD.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after clear. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	2 6	ne) 2 Medical Examiner: 0	To the best of my kno the basis of examinat ad manner stated.	ion and/or investigati	ed at the time, da on, in my opinion,	te and place, and death occurred a	i due to the cau at the time, date	use(s) and manner as and place, and due	stated. to the cause(s)
L HEERS	2	9b. Signature and title of certifier	Manner Stated.		29c, License	number		29d. Date signed	(Month, Day, Year)
	L	( Catalogue)			O.C.N	И.E.		August 23, 20	)12
5	3	Name and address of person who con			Itimore Street	Baltimore	MD 21222		

State Registrar

DHMH 17 Rev 1/2001 OCME 2006 31. Date filed (Month Q 28 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / [ Registrar	Department of H  Certificate of D	ealth and Neath		iene201	2 27454
			1. Decedent's Name (First, Middle, Last)	<del></del>		2. Date of Deat	h	3. Time of Death
	Physicia Medio		William D. Striggles			August	$2\overset{\circ}{2}^{\circ}$ $2\overset{\circ}{0}\overset{\circ}{1}$	11:43PM
1	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or I	Location of Death		4c. County of D	eath
1			Anne Arundel Medical Center	Annapoli	S		Anne Ar	undel
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth	g. Year)	Birthplace (State or Foreign Country)
	Director		260-20-7302 1X□ M 2 □ F 89	Yrs.	170010	June 20		eorgia
	nd how at	ř	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location			,	10d. Inside City Limits
	arylar a-f sl fied	Director	MD Prince George's Lanham					1 🔀 Yes 2 □ No
	or 28	Ë	10e. Street and Number	10f. Zip Code		1 -	0g. Citizen of What	71
	with th	ra	7308 Powhatan St	20706		1	USA	Country
	ems r mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-		merican Indian,
0	or ite		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 No	If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, W	
<u></u>	saftural", Exar	a pe	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2X No	Specify:		Specify: B3	Lack
<u>-</u> -	hour natu dical	Completed by	15. Decedent's Education 16a.	Decedent's Usual Occupat			16b. Kind of Busine	ess/Industry
7	in 72 e. nan "	Juc	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done du life. DO NOT use retired)	iring most of work	ing	Priva	te
7	with gien rer th	Š	8th	Truck Driver			FILVE	
Maryland 21215-0036	filed al Hy d oth	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam		faiden Surname)	
Z	ld be Ment arke	오	Jasper Striggles		Ocie Coo	per		
a	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street ar	nd Number or Rura	al Route Number,	City or Town, State,	Zip Code)
≥ `	ealth m 27		Gloria E. Striggles/Daughter 6	729 Vermont	Court, H	yattsvil	le, MD 20	)785
Baltimore,	of Hi of Hi if iten		20a. Method of Disposition  1	f Disposition (Name of ry, crematory or other place,	·)	Date	20c. Location - City	or Town, State
Ĕ	permit. Page 1 a Department of I Important: If its any injury or of		TABORA 2 - Ordination o - Tremoval non otate	y Cemetery	· i	1-2012 1	andover,	Maryland
ä	sparti sparti port ny inj		21. Signature of F al Servi e Licensee					1 Home, Inc.
n	997 8			7474 L	andover	Rd. Hyat	tsville,	MD 20785
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying,	, such as cardiac o	or respiratory arre	st,	Approximate Interval Between
1	Physician/		Immediate Cause (Final disease or condition ASPIRAT	in Pal	1-11-	1010		Onset and Death
Ť	Medical		resulting in death)  a.  Due to (or as a consequence of	of):	Eumoi	WIT		
	Examiner	,	DEME	NTIA				
	+	Examiner	Sequentially list conditions, if any, reading to him solutions are cause. Enter Underlying	f:		<i>A</i>		
	uted nd ransi	(am	Cause (Disease or injury that initiated events c.	AL VASC	10012	Acc	11 ENT	
	exection and artical-t	<u> </u>	resulting in death) Last Due to (or as a consequence of	of):				
2	ate be executed physician and the burial-transit	dical	d					
200	tifica ng pl	Me	IF FEMALE:			in the second	-	
o ×	h cer tendii or use	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	3 Ectopic pregnancy			23d. Date of	delivery
POX	deat he ati ied fo	sici	in the past 12 months?  1 Yes 2 X No 9 Unknown  1 Unknown  1 Ves C X No 9 Unknown	5 Other (specify)			Month	Day Year
j	it the	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in		- i- Dt-I			
Σ.	s tha gnec be d	þ	HYPER TEN CONTROLLING TO GREAT BUT HOL PESUILING II	in the underlying cause give	en in Pan I.		* /	e to the cause of death?
ds	equire sen si ould	ted	THER IBJUSION			1 ∐ Ye	es 2 No 3 🗆	Probably 4 Unknown
Ö	aw re as be	ed	DIABETES MELLITU	5		24a. Was ar autops		autopsy findings available to completion of cause of
vital Records,	The It ate h page	Completed	COPD			perform	ned? death	1?
ō	ian: ertifica ctor,	Be	25. Was case referred to medical examiner?	26. Plac	ce of Death (Check			
5	hysic lis ce I dire	卢	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Other	4 🗆 Nursing Ho	me 5 Reside	nce 6  Other (Sp	pecify)
5	ng Pl fter th inera		27. Manner of Dea h 1 Natural 5 Pending 28a. Date of injury 28b. T (Month, Day, Year) ir	ime of 28c. Injury a 28c work?	at	28d. Describe ho	w injury occurred	
0	endii eath. or: Af the fu	lica Lica	2 Accident Investigation		′es 2□No			
DIVISION	r Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	m, street, factory, office		28f. Location (Str City or Town,		Rural Route Number,
5	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi							,
	Hosp 4 hot Tune tely fi	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, c (Check 2 Medical Examiner: On the basis of examination and/or	death occurred at the time, r investigation, in my opinion	date and place, and death occurred at	nd due to the cau	se(s) and manner as	s stated. ne cause(s) and manner stated.
	the thin 2 the the thin 2 the the the the the the the the the the	Me	only one) 3 Certifying Nurse Practitioner: To the best of my know	vledge, death occurred at the	e time, date and pla	ice, and due to the	cause(s) and manne	er as stated.
	<b>5</b> ≥ 0 ≤ 0		29b. Signature and title of dertifier	29c. License r	number	29	Id. Date signed Mo	onth, Day/Year)
	,		CUNS Jan, MD	117	3709		00/2.	416
-	5 V		30. Name and address of persor who completed cause of death (Item 23a) (1	3.4	107 1			21/1-1
				ne PKWY #	GUT, 1th	NAHOLI	I MA	401
	Stat Registra	_	31. Date filed (Month, Day, Year)  AUG 2 8 2012	backer				
				-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012<sup>Year</sup> Aug. 25, Elizabeth Ann Spencer 12:24 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Alfred House Rockville Montgomery Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 541-46-8078 1 □ M 2 🗓 F 72 Yrs Jan. 9,1940 Washington 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Prince William Montclair 1 Yes 2 No 10e. Street and Numbe ò 10f. Zip Code 10g, Citizen of What Country? 23a Completed by Funeral 16201 Kings Valley Drive 22025 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 

✓ Yes 2 

✓ No Black White etc. 1 X Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 K No Specify: Specify: Caucasian 3 Widowed 4 Divorced Year or Dates. unk 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than traumatic event, the Mil Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill Health and Mental Item 27 is marked ပ Joseph Spencer Gertrude Lien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwen A. Huntington / daughter 17332 Blossom View Drive Olney, MD 20832 injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 8/29/12 Woodbine, MD 21. Signature of Paneral Service Licensee <sup>2</sup>Coling Home of Exemation Service P.O. Box 784 TAG al M01651 Beverly L. Heckrotte, P.A. CLarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Colon Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☒ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown o me runeral urector: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The L 24 hours after death.
 Funeral Director: After this certificate h 1 ☐ Yes 2 🛣 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted ျှ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred Living 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) Aug. 27, 2012 D52481 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Plotkin 18111 Prince Philip Drive suite 304 Olney, MD 20832 M.D.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 27456 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug. 26, Day 2012 ear 6:45P Carla Sara Scearce Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Spring House of Westwood Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 440-44-5207 Director 87 1 🗆 M 2 🔀 F Mar. 7,1925 Italy Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d Inside City Limits Director Montgomery Chevy Chase 1 Tes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5705 Brookside Drive 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. ò 1 Never Married 2 X Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Ardelia Marciasini Carlo Vittorio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe L. Scearce / Husband 5705 Brookside Drive Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of P Important: If ite any injury or of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 8/29/12 Woodbine, MD 21. Signature of Juneral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M01651 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer of Gall Bladder Duct mon Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month signed by the af Day Year 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 performed 1 ☐ Yes 2 🛣 No Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Division of Vital director. Be 26. Place of Death (Check only one) Hospital Other: 2 🕅 No 잍 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0001601 Aug. 27, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DN Frank Blackburn, M.D. 5454 Wisconsin Ave. Suite 675 Chevy Chase, MD 20815 legistrar's Signatur State back AUG Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 | 2 State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Physician/ ,Day Mary E. 2012 Sheedy August 25. 5:42P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4021 Twilight Grove Court Ellicott City Howard . Social Security Number 8. Date of Birth
(Month, Day, Year)
July 17, 9. Birthplace (State or Foreign Country)
NY If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Director 102-14-2487 1 M 2 X F 92 ຳ 1920 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Carroll Sykesville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? must be 23a Funeral 7009 Carmae Road 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc. ō Completed by 1 Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Elementary Education and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Ment. Important: If item 27 is marked any injury or con-George Wirtner Lillian McKeon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Richard E. Sheedv (Spouse) 7009 Carmae Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) <u>Garrison Forest Vet.</u> 9/4/2012 Owings Mills, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death e an each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury ce of): that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Day 1 Yes 2 S the P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? certificate Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 0 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) daughter's home 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director; After it Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation filled in by the 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and on infostigation, many section, and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and otle of 29d, Date signed (Month, Day, Year) D16206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth Pallan, M.D. 1380 Prgoress Way, Eldersburg, MD 21784

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

31. Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print)

Director

Be Completed by Funeral

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Physician/Medical Examiner

Physician

/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminar must be mailthed at apries.

Physician /Medical

For State Registrar		ur y iui	Department o Certificate o		, ,	g. No 2 0	12	27458
Decedent's Name (First, Middle, La.	ist)				2. Date of Death	1	1 has	3. Time of Death
MARGARET ANN	SCHMIT	TT (AKA	) PEGGY	SCHMITT	Month	Day	Year	4:15 PM
Facility Name (If not institution, giv	ve street and number	)	4b. City, Town	n, or Location of Death		4c. County	of Death	
canklin Squar	re HOSPI	tal_	ROSE	dale_		Bal	TIM	2000
Social Security Number 6. S	Sex 7. Ag	ge (In yrs. last bir			8. Date of Birth (Month, Day,	Year)	9. Birthp Coun	place (State or Foreign
13-30-2333	ILIM ZXIT	65	Yrs.	tys	3-30-1			RYLAND
ual Residence of Decedent a. State 10b. County		10c. City, Towr	n or Location				1	0d. Inside City Limits
	TIMORE			SEDALE				1 □ Yes 2 No
e. Street and Number			10f. Zip Coo		10	g. Citizen of V	/ What Cour	
1525 ROSEWICK	AVENUE			21237	1	-	U.S.	
. Marital Status	12. Was Decedent		13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecify Yes or No-		e - Americ	
1X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐		If Yes, specify 0		Rican, etc.)		ck, White, e	
3 Wildowed 4 Divorced	If Yes, Give Year or Dates:		l⊟ies ∠w.	No Specify:		Specify	∕: WH	IITE
15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Oc (Give kind of work do	one during most of work	ring	6b. Kind of Bu		•
Elementary/Secondary (0-12)	College (1-4or		life. DO NOT use re	etired)	".s			REGIONAL
12	5+	PH	YSICAL T		Middle M	BURN		ENTER
Father's Name (First, Middle, Last) ANDREW JOH		CHMITT,	JR	18. Mother's Name	e (First, Middle, Ma ET MA			IERTY
a. Informant's Name/Relationship(NDREW J. SCHM	(Type. Print)BROT	- 1		reet and Number or Rur			State, Zip MD	21804
	•	110	DIAMON	D MARKOR	SALISB	OKT,		
Method of Disposition	,	20b. Place of	f Disposition (Name of	f		Oc. Location -	-	wn. State
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To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trar been signed by the should be detached Medical Certification: To Be Completed by After this certificate has funeral director, page 2 s within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Registrar

State

29c. License number

D0067697

29d. Date signed (Month, Day, Year)

9000 Franklin Square Drive Baltimore md 21237

Michael Joseph	Sch		tate of Maryland	/ Depa		Health a		al Hygiene	•	112 2745
Physici		1. Decedent's Name (First, Midd	dle,Last)					2. Date of De	ath	3. Time of Death
Medical Exam	iner	BICHAEL JOS	EPH SCHLUDER					Month August 2	2, 2012 Yea	2012 hrs
		4a. Facility Name (if not institute 201 Shell Cross Farm	· =	)	4	• • • • • • • • • • • • • • • • • • • •	or Location of	Death	4c. County o	
		5. Social Security Number		- a (la	inat hidhdala.	Centreville		-	Queen A	
Funeral Director					last birthday)	If Under 1 Ye Months Da	ear If Under a	Adim		Birthplace (State or Foreign
		215-15-5764	1 X M 2 F	25	Yrs.			JOLY	8,1987	Country) MARYLAN
an y		Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Location	on				10d. Inside City Limits
		w.v. BERK	FI FV		RTINSBUR					1 X Yes 2 No
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leath ritem	Funeral	1 Never Married 2 M	Armed Forces	? <b>X</b> No	If Ye	s, specify Cub	an, Mexican, P	uerto Rican, etc.)	White	
ther d	by F	3 Widowed 4 X Div	vorced If Yes, Give Year	NO	1	Yes 2 X N	lo specify:		Specify:	WHITE
ours a		15. Decedent's Education (Spe	ecify only highest grade cor	npleted)	16a. Decedent				16b. Kind of Bus	iness/Industry
7	lete	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo	st of working in	fe. DO NOT us	e retired)		
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Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er	ဥ	JEFF GREENE	STEP-	<b>ሮ ል ጥሀ</b> ር	. 7		GULF D	r or Rural Route Nu		
and 2 lealth tem 2		20a. Method of Disposition			Place of Disposit			Date PLAN		<b>, W.V.</b> 25405 City or Town, State
Baltimore, Department of He Important: If ite		1 Burial 2 K Cremation		ا تات	crematory or other					
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Ba Perm Depa Injur	- [	21. Signature of 1 Griefal Service	Licerisee	>			AIR ROA		. MD. 21	UNERAL HOME,IN
Physician	-	23a. Part I. Enter the disease, or	complications that caused	the death.						
/Medical		failure. List only one cause	on each line.							Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons							30007
		Sequentially list conditions,	b							
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Box 68760, e death certificate be the attending physic ed for use as the bur	ian/Med	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, outcor	ne of pregr	nancy				23d. Date of d	elivery
68. certifi	ä	past 12 months?	1 Live birth 4 Pregnant at	time of de	ath -	I death 3	Ectopic pr	egnancy	Month	Day Year
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n of ling Phy After th	밁	27. Manner of Death	28a. Date of Inju	ry	28b. Time of Inj	ıry 28c. İnji	ury at Work?		how injury occurred	
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	5		d not be 28e. Place of In	ury - At ho	me, farm, street,	factory, office	building, etc.			or Rural Route Number, City
Division or At ours after defeat Direct filled in by	Certification:		mined (Specify) Fie	ld				or Town, S 201 Shell Cro	state) ss Farm Road, (	Centreville, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	cal		nysician: To the best of m							
To the Hos within 24 h To the Fun completely	듛		miner:On the basis of exar and manner stated.	nination ar	nd/or investigatio			ed at the time, date		
	Σ	29b. Signature and title of certifie		)_00		29c, Licen				(Month, Day, Year)
2 m		Ta. Ur	ronu-t	SKL	ar us	O.C.	.M.E.		August 23, 2	2012
المالات	ſ	<ol> <li>Name and address of person Patricia Aronica-Pollal</li> </ol>			,	00 M/ Balti	more Sire -	t Raltimara M	D 21222	
CA	ate	31. Date filed (Month, Day, Year)	MD. Assistant M			JU VV. Baiti	more stree	t, Baltimore, M	U 21223	
Regist		AUG 2	8 2012 Leve	المالا	A. ba	Kal				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:00 PM Physician/ Month August 24, Seymour Shapiro Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 104 Kenilworth Park Dr. Apt. 3A Towson Baltimore 7. Age (*In yrs. l*as **91** 5. Social Security Number If Under 1 Year\_ If Under 24 Hrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days (Month Day Year) 098-12-2008 **Director** 1921 New York 1 XM 2 □ F Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f shov 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 104 Kenilworth Park Dr. Apt. 3A 21204 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. WWIL 1 ☐ Yes 2 KNo Specify. Specify: White Completed 3 Nidowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Upper Management Linen Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of Page 1 and 2 should be Louis Shapiro Nettie Dickholtz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Nina Shapiro /Daughter 4E Saddletop Ct. Cockeysville, MD 21030 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Aug 27 1 Burial 2 K Cremation 3 Removal from State Beltsville, Maryland 4 Donation 5 Other (Specify) Chesapeake Crematory 2012 Signature of Funeral Service Licensee Name and Address of Facility
Cremation and Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition resulting in death) ROS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> chronic Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2  $\square$  No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature 30. Name and address person who completed cause of death (Item 23a) (Type, Print) N-Charles ST

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 08 2012 Dolores C. Travers 10:20p.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Year) 212-30-5781 Director 1 - M 2 - F Vrs 80 0111 32 MD 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ed other than "natural", or items 23a or 28a-f s event, the Modical Exorities is ust be notified Baltimore 1 XYes 2 No MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21218 U.S.A. 2219 Gilford Ave 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by Pege 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 √ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12th grade College (1-4 or 5+) f Health and Mental Hygiene. Item 27 is marked other tha Homemaker House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Helen Carter Oscar Brown traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Travers Jr-Son 2219 Gilford Ave, Baltimore, Md 21218 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I-Important: If ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) B/30/2012 Arbutus Memorial Arbutus, Md 22. Name and Address of Facility 23a. Pard 1. Enter the disease, or complications that cansed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death morediate Cause (Final disease or condition Priysician/ CHOLANGIOCARCINOMA YEAR Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ettending physician and I for use as the burlal-transit Cause (Disease or injury that initiated events Exar resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE been signed by the ettendin should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Dav 1 Yes 2 No 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has after death.

Director: After this certificate to in by the funeral director, page Hospital or Attending Physician: The perform 2 No 1 🗌 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 XOther (Specify) #05PICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ∐ Yes 2 ∐ No 2 Accident
3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 120026327 24,2012

Registrar

State

28

CAMPFIRE COLUMBIA

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 **Physician**  $A^{\ M}$ 2012 1:44 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Genesis Homewood BALTIMORE 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral**  Date of Birth (Month, Day, Year) Hours Days Min. 1 M 2 F 500-26-8217 90 Yrs Director 07-25-1922 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the fixed Evanders in ust be notified at 1 Yes 2 □ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 3712 Ravenwood Ave 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No à If Yes. Give Specify. Specify: 3 Nidowed 4 Divorced Year or Dates: Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Laundry permit. Pages 1 and 2 should be file Department of Health and Mental H-Important: If them 27 Is marked oth any Injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elijah Boyce Dorothia မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lamont Moye, Sr. / Nephew 3712 Ravenwood Avenue, Baltimore, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State King Park Cemetery 8/30/2012 Windsor Mill, MD 4 ☐ Donation 5 ☐ Other (Specify 22. Name and Address of Facility 21. Signature Vaughn C. Greene Funeral Services, 4905 York Road, Baltimore, MD 21212 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus \_\_\_\_ ach lin . Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 100 /Medical Die to (or as a consequence of Examiner emo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical the attending p as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Upknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b autopsy 2410 1 □ Yes 2 🔲 N 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ŧ Medical Certification: To 1 Inpatient this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Injury 1 Matural I hours after death. uneral Director: Aftely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours a

To the Funeral I

completely filled

P.O. Box 68766

Division of Vital Records,

State Registrar 29a, Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)



opmpleted cause of death (Item 23a) (Type, Print

1114 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year,

AMEN	D	#25,27,28A-F, PE	se Type or Print R ME G930, 8/24 State of Man	In Blac 4/12/Th	<b>K Indelib</b> RT Jenartmer	ie ink	(. Ensure /	All Copie	s Are Leç	gible.	
		1 - State Registrar	Otate of Mary		Certificat				Reg. No. 2	012	27463
Physicia Medic		1. Decedent's Name (First, Middle, Gordy C.	Tyler					2. Date of De Month Aug	ath Day	Year 3	Time of Death
Examin		4a. Facility Name (if not institution, ちいぬい 十つら		altimo			Location of Death	city	4c. County		1
Funeral Director		220.03.0526	5. Sex 7. Age (In 1 X M 2 □ F	yrs. last birthe			If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y. Year)	9. Birthplace Country)	e (State or Foreign
yland f show	tor	Usual Residence of Decedent  10a. State  10b. County	1/1/100	c. City, Town				19/02	1912	10d.	Inside City Limits
(C ( U LVV ) vith the Maryland 23a or 28a-f sho	I Director	10e. Street and Number	17		10f. Zir	Code	· · ·		10g. Citizen of		1 Yes 2 No
eath with	Funeral	4610 Beaufo	12. Was Decedent Ever		12 M/on Doors		1215			USA	
os after dall, or il	þ	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	iii 0.3.	If Yes, spec	ify Cubar	spanic Origin? (Spont, Mexican, Puerto Specify:	Rican, etc.)	Blac	ce - American II ck, White, etc. Black	ndian,
21215-0 vithin 72 hoursiene. r than "netur	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	t grade completed)		Decedent's Usua Give kind of wor fe. DO NOT use	k done de	ition uring most of work	ing	16b. Kind of B	usiness/Indust	гу
	a	8 th Orace 17. Father's Name First, Middle, La.	College (1-4 or 5+)			bor	er			ipyara	1
0 5 5 4 4 4 4	2	Benjamin Tyle	er_				18. Mother's Nam	e (First, Middle, HICKS	Maiden Surnam	e)	
0 0 0		19a. Informant's Name/Relationship Pauline S. Tyle	/		· -	(Street a	nd Number or Rura		r, City or Town, S		
Baltimore Baltimore Demit. Page 1 an Department of He Importent: If iten my Injury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Sp	Removal from State	cemetery,	Disposition (Nan crematory or o	ne of ther place	9)	Date 1 (2012	20c. Location	- City or Town,	State
Baltimo permit. Page Department. Importent: I eny Injury or		21. Signature of Funeral Service Lic		Nuclia	22. Name an	d Address	s of Facility Va	ugnn (	Green	e Funer	al Services
2		23a. Part 1. En er the disease, or co shock, in heart dilure. List onl	omplications that caused the	death. Do not	t enter the mode	of dying	ty Roa	d Kund or respiratory arr	allstow est,	Api	oroximate
Physician/ Medical Examiner		Immediate Cau Trinal disease or condition resulting in death)	a Subdural  Due to (or as a cor			wi	th hern	iation	of uncu	On	erval Between set and Death
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o be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con	nsequence of)			OFFITEICATION	APPROVED BY LE	EDICAL EXAMINES	2	
760 zate be e physicial	edical		d				CEKINIO				
Division of Vital Records, P.O. Box 68760  To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1  Yes 2	23c. If yes, outcome of print 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death	3 ☐ Ectopic p 5 ☐ Other (sp	regnancy ecify)	,			te of delivery nth Day	Year
ds, P.O uires that t n signed b	۾	Part II. Other significant conditions	s contributing to death but no	ot resulting in t	the underlying o	ause give	en in Part I.		obacco use contr		use of death?
<b>Division of Vital Records, P.O</b> tel or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by ed in by the funeral director, page 2 should be detain.	Completed							24a. Was a autop perfor	sy r med?_ c	Were autopsy fi prior to comple death?	ndings available tion of cause of
/ital sician: certific director,	Be	25. Was case referred to medical examiner?  1 X Yes 2 No	Hospital:				ce of Death (Check	only one)			
1 of \ling Phy Ing Phy After this funeral of	ate: To	27. Manner of Death  1 Natural 5 Pending	1 ☑ Inpatient 2 28a. Date of injury (Month, Day, Yea	28b. Tim	ne of 28	c. Injury a work?	at Nursing Ho	28d. Describe h	ow injury occurre		
Division of Vital Rec of Attending Physician: The la after death. Director: After this certificate ha d in by the funeral director, page:	Certificate:	2 X Accident Investigat 3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	28e. Place of Injury - A building, etc. (Sp.	At home, farm	M , street, factory,	1 🗆 Y	′es 2XI No S	SUBJECT 28f. Location (S. City or Town	treet and Numbe	or Rural Rout BEAUF	ORT AVE
Hospite 24 hours Funeral etely filled	Medical	CHECK 2 - Medical Exa	HOME hysician: To the best of my k miner: On the basis of examin	nation and/or in	nvestigation in n	v oninion	date and place, an	the time date ar	use(s) and mann	to the equecate	and manner stated.
To the within To the compl		only one) 3 Li Certifying N 29b. Signature and title of certifier Adukum	urse Practitioner: To the best	t of my knowle	dge, death occu 29c.	rred at the License r	e time, date and pla number	ce, and due to th	e cause(s) and m 29d. Date signed	anner as stated	(ear)
		30. Name and address of person wh	o completed cause of death (	(Item 23a) (Typ	pe, Print)	Ш	ospital	ot n	Saltin	NOYP	,
State Pegistra		31. Date filed (Month, Day, Year)  AUG 2 8	1 32 Abdietrarie Si	ignature	park	(1)	C. Spires	0			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27464 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Frank Joseph Tischler 5:30 P M Medical August 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 215 Belmont Forest Ct. #207 Baltimore Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 212-26-5703 Director 1 **X** M 2 □ F 80 Sept 18. 1931 Maryland if than "natural", or items 23a or 28a-f show the Medical Examinar past be rectifued at permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumetic event, the Marical Examinations is any large. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Timonium 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 215 Belmont Forest Ct. #207 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Yes 2 No f Yes, Give Black, White, etc. ۾ 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Engineer **BGE** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Tischler Catherine Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Y. Tischler/ Wife 215 Belmont Forest Ct. #207 Timonium, MD. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation \_5 ☐ Other (Specify) Hilltop Service Co. 8-27-12 Towson, MD. 21. Signature of Fun al Service Live see 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence mal bleeding Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown eath but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 WN 1 ☐ Yes 2 ☐ No BB 26. Place of Death (Check only one) examiner? 읻 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of D ath

Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Division of Vital Records, P.O. Box 68760 Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title cause of death (Item 23a) (Type, Print) 31. Date filed (Mon State 2 8 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 27465 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Betsy Cates Taylor 11:45 PM August Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City Encore at Turf Valley Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Min. 1 🗆 M 2 😾 F Davs Hours 89 Director North Carolina 237-28-8540 14 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🖾 No Florida Pasco Port Richey 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 11130 Carriage Hill Drive #5 USA 346.68 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry الم filed win. خاط Hygiene. خود than "r" Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene. Important: if item 27 is marked other the any injury or other traumatin mental proces. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jessie Lloyd Claud Cates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5539 Phelps Luck Drive; Columbia, MD 21045 Claudia Yanacek Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 8-21-2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Atlantic Crematory Signature of Funeral Service 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road; Columbia, MD 21045 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 VC1 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 [ 1 Inpatient 2 ER/Outpatient 3 DOA မ Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

Box 68760 P.O. Records, To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has Division of Vital completed filled in by the funeral director,

> 5 who completed cause of death (Item 23a) (Type, Print) 30. Name and address COLUMBIA MD State 2 8 Registrar

29a. Certifier (Check 29b. Signature and title

certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

21044

29c. License numbe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 27466 State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		tificate of D	eath (		Reg. No.				
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Elsie Eveli Elsie Evelyn Thomas	ne Thomas	S		2. Date of Dea	ath	3. Time of Death 8:20 a. M			
-	Examir		4a. Facility Name (if not institution, give street and number) 1423 Francke Ave.	4b. City, Town, or Luther	ville		4c. County of Death Baltimore					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In 1)  Usual Residence of Decedent 7. To 2 7. Age (In 1)  Usual Residence of Decedent 7. Age (In 1)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 12.9					
e, Maryla	faryland 8a-f show tified at	Funeral Director		c. City, Town or Loca Luthervi					10d. Inside City Limits 1 ☐ Yes 2 ♣ No			
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		10e. Street and Number 1423 Francke Ave.		10f. Zip Code 21093			10g. Citizen of What Country? USA				
			11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Ever in Armed Forces or 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 🟋 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A	American Indian, Vhite, etc. W			
		Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary Seconday (0-12)  College (1-4 or 5+)	(Give ki life. DO	ent's Usual Occupa ind of work done do NOT use retired) emaker		king	16b. Kind of Busine				
		To Be	17. Father's Name (First, Middle, Last) William Wallce Allan			18. Mother's Nan Evelin	ne (First, Middle, 1 <b>e Vera</b> Vera-Ho	Maiden Surname) <b>Holwell Stwell</b>				
			19a. Informant's Name/Relationship (Type, Print) Husband/Albert Charles Thom	as 1423	3 Francke			r, City or Town, State le, Maryla				
	t. Page tment c rtant: If njury or		1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	DVMG-Du	atory or other place 11anev Va	11ev 8/2	7/12	20c. Location - City	Marvland			
Ba	permi Depar Impo any ir		21. Signature of Grienal Sevice Licensee  Michael Flagle	Len	mon Fune	ral Home	of Dula	aney Valle	Timonium,MD			
	Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the cand shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a con Sequentially list conditions,	phy se		_		est,	Approximate Interval Between Orset and Death			
Records, P.O. Box 68760	rtificate be executed ing physician and e as the burial-transit		if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	res that the death certificate signed by the attending phy I be detached for use as the	Physician/Med										
	requires that the state of the	ρ	23e. Did tobacco use contribute to the cause of death									
	I <b>Physician</b> : The law re r this certificate has be aral director, page 2 shc	Completed					24a. Was a autop perfor 1  Yes	sy prior death	autopsy findings available to completion of cause of n? Yes 2  No			
ita	ician: certific rector,	Be	25. Was case referred to predical examiner?  1  Yes 2 No Hospital:		Othor	ce of Death (Chec						
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death expension 24 hours after death this certificate has been signed by the attend completed filled in by the funeral director, page 2 should be detached for use	cate: To	27. Manner of Death 28a. Date of injury	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing			p Home 5  Residence 6  Other (Specify)  28d. Describe how injury occurred					
		Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - A building, etc. (Spe		et, factory, office		treet and Number or n, State)	Number or Rural Route Number,				
			29a. Certifier (Check only one)  1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated occurred at the time, date and place, and due to the cause(s) and manner as stated.									
	<b>5</b> × <b>6</b> 0		29b. Signature and title of certifier	kim .	29c. License	number DY3	31 1	29d. Date signed (Mo	onth, Day, Year)			
	in/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  VINCENT P-W:06 Lew 5k mb 1623 Bellong Ale. 5199									
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature ignature	162	3 Be110	ma th	2.	21093			
	Registra	_	ALIC 9 Q 2012 6	60 Nad								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 8/23/2012 Stella D. Tadkowski 4:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h City Town or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Hours Director 218 05 3475 92 1 M 2 X F 11/16/1919 MD Usual Residence of Deced 28a-f show 10a. State 10b. Count 10c, City, Town or Location be notified at Director 10d. Inside City Limits MD Baltimore 1 Yes 2 V No Nottingham 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a with **Examiner must** 4019 Farmdale Rd. 21236 U.S.A items death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black White etc. Completed by "natural", or 1 Never Married 2 Married 1 ☐ Yes 2 X No 21215-0036 1 ☐ Yes 2 👿 No Specify: If Yes, Give Specify White 3 ▼ Widowed 4 □ Divorced Year or Dates r than "nature the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other tha the 12 years T. Talbott Bond Bookkeeper traumatic event, Be filed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Waclaw Dlabich Catherine Kaliczynski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Smedberg (niece) 4019 Farmdale Rd Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or or on once. cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 8/27/2012 Dunda1k 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusing a contract of the Funeral Director. the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: page 2 should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Dav Year 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 X No 1 Yes the funeral director, Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🕱 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No X Natural 5 Pending Accident Investigation 2 ☐ Accider 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) R130272

Registrar
DHMH 17 Rev 06-2011

State

TRACIE L.

31. Date filed (Month, Day, Year)

10 pm

AUGUST

TADKOWSKI

STELLA

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORGAN, CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylar					and Me	ental Hy	/giene	2 n	12	271.68
			1. Decedent's Name (First, Middle, Last)  Certificate of Death						2	2. Date of Death 3. Time of Death					
	Physicia Medi		Elmer Luke Titus							Month Day Year				02:43A M	
	Examir	ner	4a. Facility Name (if not institution,		er)		4b. City, To			f Death		40	c. County	of Death	
	Funeral		St. Agnes Hospi 5. Social Security Number		. Age (In yrs. I	ast birthdav)	Ba1		ore	24 Hrs. I g	B. Date of Bi	rth.		0 Dirtho	lace (State or Foreign
	Director		219-26-3344	1 🙀 M 2 🗆 F	7:		Months	Days	Hours	Min.	(Month, Da	ay, Year)		Count	ry)
9	land show d at	Ļ	Usual Residence of Decedent  10a. State  10b. County		10c Cit	y, Town or Lo	cation			ĮN	ov. 4	<b>,</b> 19	39	Mary	land Od. Inside City Limits
	farylar Sa-f s tified	ecto	MD			ltimore									1XXYes 2 No
	with the Maryland 23a or 28a-f show ust be notified at	ă	10e. Street and Number				10f. Zip C	ode				10g. Ci	itizen of W	/hat Count	
	ms 23 must	<b>Funeral Director</b>	647 Charraway	Road				2122					US	SA	
(0	s after deat ral", or iter Examiner	by Fu	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 √ Marri</li></ul>	12. Was Deced	es?	3. 13. 1	Was Deceden f Yes, specify	nt of His Cuban	panic Origi , Mexican,	in? (Specif Puerto Ric	y Yes or No- can, etc.)			- America	
036	rs afte iral", ( Exan	ed b	3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 If Yes, Give Year or Date			Yes 2	X No	Specify:				Specify:	Whi	te
15-0	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Completed	15. Deceden (Specify only highes			16a. Deced	dent's Usual (	Occupat done du	tion trina most o	of working		16b. k	Kind of Bu	siness/Ind	ustry
121	ithin 7	Com	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. D	O NOT use re cionary	etired)		3		F.		· · · · · · · · · · · · · · · · · · ·	_
Pd 2	illed wall Hyg	Be	17. Father's Name (First, Middle, La			Deat	Lionary				irst, Middle,		ngine Surname)		<u>g</u>
ylar	ld be i Menta larked atic e	2	Charles O. Ti	tus	_				Ma	argar	et M.	Doug	glas		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exanone.	- 1	19a. Informant's Name/Relationshi			19b. Mailir	ng Address (S	treet ar	d Number	or Rural R	oute Numbe	er, City or	r Town, Sta	ate, Zip Co	ode)
<u>ə</u>	and the Healt tem 2		Barbara Thomas 20a. Method of Disposition	Titus	20b P	647 (Place of Dispo	Charray	vay	Road	Balt:					04-4-
Baltimore,	Page 1 lent of nt; If i		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 Removal from S	tate C	emetery, cren	natory or othe	er place,					ocation - (		•
alti	permit. F Departm Importa any inju once.		21. Signature of Funeral Service Lie		) ACI		. Name and A			Ambro	,2012 ose Fu	iner	al Ho	me.	Inc.
<u> </u>	20 E E O		Jelle C.	from	<u></u>	13	328 Sul	Lphu	r Spi	ring I	Road A	rbu			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										Interval Between		
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a Sep	Sis									ã	Onset and Death
	Examiner		Due to (or as a consequence of):  Preumonia  Luck												
	- ±	jner	Sequentially list conditions, if any, leading to immediate	Due to (or	as a consequ	ence of):									1
	ecutec and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Ker	as a consequ	eilu	e'								1 well
0	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.  Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical E	rosulting in doctry East	200 10 (0)	as a consequ	erios oi).									
3760	ificate ig phy as the	Medi	IF FEMALE:	G			_								
Box 687	eath certificat attending phy for use as th	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 Live Bir	th 2 Fetal	Ideath 3 🗆	Ectopic pres	anancy					23d. Date	of deliver	y
Bo	the at	Physician/Me	1 Yes 2 No 9 Unknown	4 ☐ Pregna 9 ☐ Unknov	nt at time of d	eath 5	Other (speci	ify)					Mont	th C	Day Year
P.O.	requires that the decensions to be sensioned by the schooled be detached	by Ph	Part II. Other significant condition	s contributing to dear	th but not resu	ulting in the ur	nderlying caus	se giver	n in Part I.		23e. Did to	bacco u	ise contrib	oute to the	cause of death?
ds,	quires en sign ould be	ed b	1 ☐ Yes 2 ☑ No 3 ☐ Proba									ably 4 🗆 Unknown			
COL	aw rec as ber 2 sho	Completed									24a. Was autop		24b. We	ere autops	y findings available pletion of cause of
Re	sician: The law certificate has b lirector, page 2 s										perfo 1  Yes	rmed?	de	ath? Yes 2	
/ital	ysician is certif directo	m	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:				06. Plac		(Check on					
of \	g Phy er this neral c	e: 1	27. Manner of Death	28a. Date of	oatient 2 🗆 I	28b. Time of	28c.	Injury a			5 Resid				
lon	Attending Pirdeath.	fica	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	tion	Day, Year)	injury		work? 1 ☐ Ye	s 2 🗆 N						
Division of Vital Records,	or Att after d Direct in by	Certificate:	4 Homicide determin	ad 28e. Place of	Injury - At hor etc. (Specify)	me, farm, stre	et, factory, of	fice		28f.	Location (S City or Tow			or Rural R	oute Number,
Ω	spital nours neral y filled	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
	To the Hospital or Atteno within 24 hours after death To the Funeral Director: , completely filled in by the	Medical	only one)  Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									o(c) and manner etated			
	Neith No.	1	29b. Signature and title of certifier	01			29c. Lic		umber			29d. Dat	e signed (i	Month, Da	y, Year)
			HSTVa.	Bhatt	of don't /!!	020) /5:	<u>as</u>	24	385	28.4	512	8	25	12	
10+		ľ	30. Name and address of person wh Astha Bhott	COMPleted cause of	death (Item :	∠Jaj (Type, Pr	Ave	Br	2 (fi	mar	x 1	40	21	22	9
	State	7	1. Date filed (Month, Day, Year)	32. Regi	strar's Signatu				0011	2	, -				1
SI/ DIII	Registra  1H 17 Rev 06-20		AUG 2 8 2012	Bush	, A.	park									
K DHIN	17 Nev 06-20	711													

5:10 a.m. AUGUST 26, 2012

MELVIN VITO

				pe or Print in				-		jible.
			For State Registrar	State of Marylar		artment of I tificate of I			giene Reg. No.	012 27469
	Physici: Medi		1. Decedent's Name (First, Middle, Last)  Melvin Nicho	las Vito				2. Date of De Month August		2 3. Time of Death 5:10 A M
7	Exami		4a. Facility Name (if not institution, give stree				r Location of Death		4c. County	y of Death
	Funeral	7	Stella Maris  5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	nium If Under 24 Hrs.	8. Date of Bird	th	timore  9. Birthplace (State or Foreign
	Director		Usual Residence of Decedent	<sup>2 □ F</sup> 71	Yrs.	Months Days	Hours Min.	Feb. 24		Country) Maryland
	aryland a-f sho fied at	Director	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	the Ma a or 28; be notif	Pig I	MD Baltimore	9	Wind	sor Mill			10g. Citizen of	1 ☐ Yes 2 💢 No What Country?
	ath with	Funeral	3128 Rices Lane	Was Decedent Ever in U.	6 112 1		244			States
920	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	ğ	1 Never Married 2 Married	was becedent Ever in 0.: Armed Forces? ! X Yes 2 ☐ No f Yes, Give Year or Dates.	l II	Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ce - American Indian, ck, White, etc. " White
21215-0036	72 hour n "natu ledical	Completed	15. Decedent's Educat (Specify only highest grade co	ion	(Give k	ent's Usual Occup ind of work done o	ation during most of work	ing	16b. Kind of B	usiness/Industry
212	within giene. ner thar t, the N		Elementary/Secondary (0-12) (	College (1-4 or 5+)		NOT use retired)	er		Truck	ing
Baltimore, Maryland	age 1 and 2 should be filed ent of Health and Mental Hy it: If item 27 is marked ott y or other traumatic even	To Be	17. Father's Name (First, Middle, Last)  Guy Vito				18. Mother's Nam Heler	e (First, Middle, 1 Teabo	Maiden Surname	e)
Mar	12 shoualth and 27 is n	7	19a. Informant's Name/Relationship (Type, P Carol Vito (Wife)	rint)	1		and Number or Run ne. Winds			State, Zip Code) and 21244
iore,	permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rem	oval from State	Place of Dispos cemetery, crem	sition (Name of atory or other plac	:e)	Date	20c. Location -	- City or Town, State
altin	permit. Pa Departmer Important any injury once,	d	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service LicenseeA	Met						lle, Maryland of MD, Inc.
m	a m Dee	- 13	Spouling	Jon	29	9 Freder	ick Road,	Catons	ville,	Maryland 21228
) )	Physician/ Medical		23a. Part 1. Enter the disease, or complicating shock, or heart failure. List only one can almost a cause (Final disease or condition resulting in death)	use on each line.  LIVER CANCE  Due to (or as a consequence)	R	the mode of dying	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
garant.	Examiner	_	Sequentially list conditions, b. —							
	executed an and urial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
	cate be exe physician s the burial	edical E	d	- Duo to (or as a consequ						
. Box 68760	Frogstra or Attending Physician: The law requires that the death certificate be set hours after death.  Fur hours after death,  Fur horse and the function of the set of the set of the set of the attending physicial etely filled in by the funeral director, page 2 should be detached for use as the burner of the set of t	Physician/Medical	in the past 12 months?	yes, outcome of pregna Live Birth 2 Feta Pregnant at time of c Unknown	ıl death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Dat	te of delivery nth Day Year
, P.O.	es that the igned by be deta	by	Part II. Other significant conditions contribu	iting to death but not res	ulting in the ur	derlying cause giv	en in Part I.			ribute to the cause of death?
ords	v require been s should	Completed				<del></del>		1 □ Y	_/\	3 Probably 4 Unknown  Were autopsy findings available
Rec	<b>nysician:</b> The lav nis certificate has I director, page 2							autop perfor 1  Yes	med?	orior to completion of cause of death? I □ Yes 2 □ No
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ▼ No Hospit	al: 1  lnpatient 2	EP/Outpatiant	Otho	r:		. <b>V</b>	TO THE HOOD OF
n of	ding Phy h. After thi funeral		1 X Natural 5 Pending	Ba. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work?	at .		ow injury occurre	er (Specify) <b>HOSPICE</b> ad
Division of Vital Records,	or Attendated after death Director.	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	le. Place of Injury - At ho building, etc. (Specify)	me, farm, stree		Yes 2 No	28f. Location (St City or Town		er or Rural Route Number,
	tospital 4 hours uneral ely fillec	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: O	To the best of my knowle	edge, death or	ccurred at the time	, date and place, ar	nd due to the cau	use(s) and mann	er as stated. to the cause(s) and manner stated.
:	Io the Hospital of A within 24 hours after To the Funeral Direct completely filled in by		only one) 3 X Certifying Nurse Pract 29b. Signature and title of certifier	ctitioner: To the best of m	ny knowledge, d	leath occurred at the	e time, date and pla	ce, and due to th	e cause(s) and m	nanner as stated.  (Month, Day, Year)
	W		* Mouresc	INT		RIY	9792		8/27	2012
-	d1 V		30. Name and address of person who comple  JACKIE JONES, CRNP	ted cause of death (Item 2300 DULAN			TIMONIUN	f. MD 21	093	
	Stat Registra	-	31. Date filed (Month, Day, Year)  AUG 2 8 2012	32 Registrar's Signatu				<u> </u>		
DUL.	H 17 Rev 06-2		AUG & COIL	many p	·					

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2

				Plea						nd Mental Hyg			2747	n
			1	For State	State	oi waryiai		tificate of l				1 4	6141	O
				1. Decedent's Name (First, Middle,	Last)			tillcate of t	Jean	2. Date of Dea	eg. No.		3. Time of Death	
		Physicia Medic	al .	BARBARA JACOB	S VAN	RIPER				August	25, 2		8:03A	М
4		Examin		4a. Facility Name (if not institution,	give street and nur	mber)		4b. City, Town, c		Death		y of Death		
				Stella MAris  5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	Timoniu		Hrs. 8. Date of Birth		timo	re place (State or Fore	ian
		Funeral Director		274-20-6387	1 □ M 2 <b>XX</b> F	90	Yrs.	Months Days		Min. (Month, Day,	Year)	Cou	ntry)	,,,,
				Usual Residence of Decedent						07/15/1	922		hio	
		yland •f sho ed at	ctor	10a. State 10b. County		10c. C	ity, Town or Lo						10d. Inside City Lim	
		r 28a	Dire	Maryland None  10e. Street and Number			Balti	10f. Zip Code			10g. Citizen of	What Co.		
		permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	4100 North Char	·les Stre	et #810		21218	}		0	JSA		
		death items ier m		11. Marital Status	12. Was Dec Armed F	cedent Ever in U	.S. 13.	Was Decedent of H	lispanic Origir an, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)		ce - Ameri ack, White,	ican Indian, , etc.	
<b>1</b> •	36	after (", or xamir	d by	1 ☐ Never Married 2 ☐ Marr 3XXWidowed 4 ☐ Divorced	If Voc Ci	orces? XX No ive		1 □ Yes XX No			Specify		White	
a.n	21215-0036	atura cal E	Completed		Year or Ent's Education	Dates.	16a. Dece	dent's Usual Occu	oation		16b. Kind of E			-
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8:03	21	withii giene ner th t, the			4			<u>Homemaker</u>				vn Ho	me	
	pu	tal Hy ed ott	To Be	17. Father's Name (First, Middle, L	ast)				1	s Name <i>(First, Middl</i> e, <i>I</i> : ille McMil		ie)		
2012	ry la	uld be d Men narke natic		Joseph Jacobs	in (Time Delet)		101 11 70	A 1 d (O4 4		or Rural Route Number	_	State Zin	Cadal	
7	Maryland	2 sho th and 27 is r traun		19a. Informant's Name/Relationsh  Tracy Van Riper		DTR				e, NW #1503				37
	ē,	f Heal f Heal item		20a. Method of Disposition  1  Burial 2  Framation		20h	Place of Dien	neition (Name of	1	Date	20c. Location			
T	mo	Page nent o int: If iry or		1 Burial 2 <b>A</b> remation 4 Donation 5 Other (S	3 ☐ Removal from pecify)	m State Me	etro Cr	matory or other pla ematory	08	3/28/2012	Baltimo	ore,	Maryland	
AUGUST	Baltimore,	rmit. F spartm porta porta y inju		21. So ature of Funeral Servi L	71.	anh.	2	2. Name and Addre	ess of Facility	litchell-Wi d Baltimro	edefelo	J. Fun	eral Home	Inc
AU	<u>m</u>	9 9 F 8 9		Kenny Syl	Menre	Makes	1	6500 Y	ork Roa	d Baltimro	e, Mary	/ Land		
				23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that inly one cause on (	t caused the dea each line.	ath. Do not ent	er the mode of dyl	ng, such as ca	irdiac or respiratory arr	est,		Approximate Interval Between Onset and Death	
4	*.	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. SEPS							_	0.1001 4.14	_
		Examiner		resulting in deathy	Due to	o (or as a conse	quence of):							
			Jer	Sequentially list conditions,	b. Due to	o for as a conse	uence of							
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ER	9876	artifica ding p	/Me	IF FEMALE:	23c. If yes, o	utcome of pregi	nancv				234 5	ate of deli	iven	
RIPER	Box (	ath ce attend for us	cian	23b. Was decedent pregnant in the past 12 months?	1 🗆 Liv	e Birth 2  Fe	etal death 3	Ctopic pregnar Other (specify)	ncy		1	onth	Day Year	
	Q.	he de y the ached	hysi	1 ☐ Yes 2 👿 No 9 ☐ Unknown	9 🗌 Un									
VAN	P.0	ician: The law requires that the death certificate is certificate by the attending physicator, page 2 should be detached for use as the	y P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the	underlying cause g	jiven in Part I.				the cause of death?	- 11
RA	ds,	quires en sig ould b	pe					<u> </u>		1 🛄 '			robably 4 🗌 Unkn	- 11
BARBARA	Records,	aw rec as bee 2 sho	Completed by							24a. Was autop	sy	prior to c	topsy findings availa completion of cause	of
BAI	Re	The la ate ha	Con							1 🗆 Yes	rmed? 2 <b>X</b> No	death?	2 🗆 No	
	Vital	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Ot		(Check only one)				
	ξ	Physi this c	2	1 Yes 2 No 27. Manner of Death	28a. Dat	Inpatient 2 [	ER/Outpatie	nt 3 L DOA	4 □ Nun	sing Home 5 Resid			ify) HOSPICE	-
	n of	ding th. After fune	cate	1 X Natural 5 Pendir 2 Accident Investi	ng (Ma	onth, Day, Year)	injury	wo	rk? ☐Yes 2☐1	1				
	Division	Atten	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - At Iding, etc. (Spec	home, farm, st	reet, factory, office		28f. Location (S City or Tow		ber or Rui	ral Route Number,	
	Div	tal or is afte al Dir			1					1				
		To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 🛄 Medical I	Evaminer: On the h	asis of examinat	ion and/or inve	stigation in my opin	nion, death occ	place, and due to the ca curred at the time, date a e and place, and due to t	nd place, and c	due to the d	cause(s) and manner	stated.
		o the	Σ	only one) 3 X Certifying 29b. Signature and title of certifie		er: 10 the best o	i iriy knowledg		se number	and place, and due to t	29d. Date sign			
4		F>F0		> 14AIN	esCANT	0		B	14970	72	8/2	7/2	12	
1		J Hr		30. Name and address of person	who completed ca	•								
		1 0		JACKIE JONES,				ALLEY RD.	TIMO	NIUM, MD 2	1093			
		Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	nature A							

12-06324 Ma

2-06324 ark Edward Va	assi	•	e <b>ase Ty</b> St	oe or P ate of N	rint in B Naryland	7 Бера	i uneni c	л пеа	iiiii anc	All Co	<b>opies</b> al Hygi	<b>Are Le</b> ene	egible	20	12	2747
		1- For State Registrar				Cer	tificate c	f Dea	th			F	Reg. No.			
Physici ledical Exami		Decedent's Nam	e (First, Midd	e,Last)	Mark Ed	ward Va	assie					Date of De Month ugust 2	Day	Year 2	;	3. Time of Death 0815 hrs
4		4a. Facility Name (	if not institution	n, give stree			3	4b. City,	Town, or L	Location of				. County of De	ath	
		23 Diane D	rive					Loth	ian				A	Anne Aruno	lel	
Funeral		5. Social Security N	Number	6. Sex	7. Ag	ge (In yrs. la	ast birthday)	If Und	der 1 Year	If Under	24Hrs. 8.	Date of B	irth (MM/			place (State or
Director		214 66 2	0.40	1 X M	2F	1.1	Yr	Mont	ths Days	Hours	Min.	01/2	20/104	Fo	reign Cour	Maryland
		214-66-2 Usual Residence o				44		<u>.                                    </u>		1		01/2	29/19	36		viai yiailu
ROY		10a. State	10b. County			10c. City,	Town or Loca	ition							1	0d. Inside City Limits
	<b>.</b>	MD	Λr	ine Arur	ndal					Lothia	an					1 X Yes 2 No
Maryland 28a-f show	ಚಿ	10e. Street and Nu		ille Alui	idei	l	_	10f, Zi	p Code	Louna	an		10g. Citi	zen of What C	ount	v?
or 2	Director	23 Diana Di								2071	1	ŀ			US	Δ.
with the Mary ms 23a or 28a be notified at	<u>''a</u>	11. Marital Status	ive	12.1	Was Decedent	Ever in II	S 113 W	as Deced	lent of Hisr		in? (Specif	v Yes or N	o- 1			an Indian, Black,
ath y	Funeral	1 Never Marri	ed 2 M		Armed Forces	?					Puerto Rica		<u> </u>	White, etc		ir ir arai ir piask,
ter de		3 Widowed	4 Div	orced If Yes		<b>⋉</b> No	1	Yes :	2 No	specify:				Specify:	V	/hite
urs af	l by	15. Decedent's Ed	_	I or Da	toe.	npleted)	16a. Decede				ind of work	done	16b.	Kind of Busine		
2 ho	etec	Elementary/Seco			ollege (1-4 or		during r	nost of wo	orking life.	DO NOT u	use retired)					
5-0036  within 72 hours after death with the Maryland tygien with the Maryland other than "natural", or tiems 23a or 28a-f she the Medical Examineer must be notified at socc	Completed	12			2				Field N	1anager	r				Sal	es
5-0 ed wi	Cod	17. Father's Name	(First, Middle,	Last)					1	8.Mother's	Name (Fir	st, Middle,	Maiden	Surname)		
21; be fill ntal I	Be			Fred	erick Vass	sie						Ca	irolyn	Eiholzer		
ould d Me	ဥ	19a. Informant's Na	me/Relations	hip (Type, P	rint )		19b. Mailir	ng Addres	s (Street	and Numb	oer or Rural	Route Nu	mber, C	ity or Town, St	ate, Z	(ip Code)
MD i 2 sh th an i 27 i		Carolyn V		lother							MD 207	711				
Titen		20a. Method of Dis			16.00		lace of Dispo rematory or o			netery,	Da	ite	20c.	Location - City	or To	own, State
TOTAL			Other Sa		emoval from St	a(c)	Chesapea			,	8/28/2	2012		Relts	vill	e, MD
Baltimore, MD 21215-0036  pernit. Pages and 2 should be filed within 72 hours after Department of Filed and Monda be filed within 72 hours after Important: If item 27 is marked other than "natural", injury or other traumatic evect, the Medical Examiner.	- 1	21. Signature of Fu				`			d Address		0/20/2	.012		Detto	, V 111	c, mb
E P P W		Dorota Ma	arsha([	bush	all le	ulua	all 1	Marvla	nd Cre	mation	Service	es. PO	Box 1	413 Balti	mo	re, MD 21203
Physician		23a. Part I. Enter th	e disease, or	complication	ns that caused	the death.										Approximate Interval Between Onset and
Medical	1	Immediate Cause (	•		∍. oral gunshe	ot wound									-1	Death
Examiner		or condition resulting			o (or as a cons										$\neg$	
		Sequentially list co	nditions,	b											4	
	Examiner	if any, leading to im cause. Enter Unde		Due to	(or as a cons	equence of	):									
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executed an and al - trans	ical	UNPENDED		AME	ENDED											
68760, certificate be nding physici se as the buri	Je d	IF FEMALE:		230	. If yes, outcor	me of prean	ancy						230	d. Date of deliv	/erv	
rtifica	2	23b. Was decedent past 12 months		e 1	Live birth	ne er pregn		etal death	3 [	Ectopic	pregnancy			Month	Da	y Year
Box 68760, s death certificate be the attending physic of for use as the bur	: <u>ë</u>	1 Yes 2 N		nown 4	Pregnant at	time of dea	ath 5 C	ther (Spe	ecify)				1			
BC ne dear the z	Physician/Med			9	Unknown											
Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for 1	by F	Part II. Other signi	ricant conditi	ons contri	ibuting to deat	h but not re	sulting in the	underlyin	g cause giv	ven in Part	11.					e cause of death?
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ecc he lar ate ha	팅												ormed? 2 ✓ N	death	? Yes	2 \ No
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Division of Vital Records, tal or Atteoding Physiciae: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be the funeral director, page 2 should be the funeral director.	To Be	examiner?	2 No	Hospita	II: 1 Inpatie	ent 2	ER/Outpatien	t 3 🗌 [	DOA C	Other4	Nursing Ho	me 5	Reside	nce 6 🗸 Ot	her: S	cene
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eedic		1 Natural	5 Pend	ing	OUND: Day,Y Aug 22, 2012		FOUND: 0758 hrs		1 Y	es 2 🗸 N	No Sub	ject sho	ot self			
/iSi r Att ter de irect	필	2	_ [	riguitori	8e. Place of In			et, factor	y, office bu	iilding, etc.	. 28f.			nd Number or	Rura	Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Atteodiog Physiciao: The law requires that the death certificate be within 24 hours after death.  To the Fuoreral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Certification:	4 Homicide		material and	Specify) Re	sidence					23 🛭	or Town, S Diane Driv	state) ve, Loth	ian, MD		
Hosp 24 hor Fuoc rely fi		29a Certifier	Certifying Ph	ysician: To	the best of m	y knowledg	e, death occu	rred at the	e time, dat	e and plac	e, and due	to the cau	se(s) an	d manner as s	tated	
thin ithin ithe	edical	1-11-11		niner:On th	e basis of exa											
F. 2 F. 8	Š	29b. Signature and	title of certifie		nanner stated.	1		29	c. License	number			29d. I	Date signed (i	Vonti	, Day, Year)
		lat.	111	1	1 19	4	7		O.C.M	1.E.			Aug	ust 23, 20	12	
In on		30. Name and addre	ess of person	who comple	eted cause of d	leath (Item )	23a)									
12 11		Zabiullah Al					,	Baltimo	re Stree	t. Baltim	nore. MC	21223				

State 31. Date filed (Month, Day, Year) Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Aug 28 2012 Barbara E. Wantz 6:05A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3034 Old Gamber Road Finksburg Carroll Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 220-34-5544 Country) **Director** 1 M 2 F 73 12/25/1938 MD Usual Residence of Decedent fshow at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sh notified a MD Carroll Westminster 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 3034 Old Gamber Road 21048 United States filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify.White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Ith and Mental Hygien 27 is marked other the r traumatic event, the Housekeeper Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ၉ John Beck Dorothy Meekins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Humple-daughter 3034 Old Gamber Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🗆 Burial 2 📉 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crem 8/28/12 Sykesville Service Licensee 21. Signatu 22. Name and Address of FacilityFletcher Funeral & Cremation 254 E. Main St., Westminster, MD 21157 P4(1) Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a lonsequence of) Examiner D Sequentially list conditions, as a cor sequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events attending physician and for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown be detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 **N**o ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending ie Hospital or Attendin 124 hours after death. e Funeral Director: Aft 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be the 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 12mg 2012

W DHMH 17 Rev 06-2011

Registrar

Beorgetown

Blad. Sykesville, mi

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 28 6/90

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:20 PM 2012 Margaret Woodard 22 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** (Month. Dav. Year) Davs Hours 213-30-7060 79 Director 1 □ M 2 🗓 F 0.5 33 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State "natural", or items 23a or 28a-f sho death with the Maryland Director 1 X Yes 2 No MD NA Baltimore 10f. Zip Code 10a Citizen of What Country? 10e. Street and Number Funeral 21209 5711 Rockspring Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in LLS 14. Race - American Indian, Armed Forces?. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Completed 3X Widowed 4 □ Divorced other traumatic event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than lementary/Secondary (0-12) College (1-4 or 5+) 12th grade Registered Mt. Sinai Hospital 4yrs Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 John Woodard Lillie Frazier of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4.5 2521 Strothers Road, Blair, SC 29015 Geraldine Woodard Trapp Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. Marks Baptist 8/29/2012 Ridgeway. Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Fibrillation disease or condition resulting in death) Ventricular Medical Due to (or as a consequence of): **Examiner** Coronery Sequentially list conditions, Due to (or as a consequent e of) Examine if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury Due to (or as a consequence of): burial-tran that initiated events resulting in death) Last signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the k IF FEMALE nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No detached for Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertusion page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed Yes 2 1 Yes 2 No 25. Was case referred to medical exampler?

1 2 Yes 2 1 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) the 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 05906Z M.A. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 06-2011

2401

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Ler<u>oy</u> Williams 2012 4 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) , or Location of Death **Examiner** BALTIMORE HOSDITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Jan 30 1926 228-34-7406 **Director** 1 X M 2 □ F 86 Va or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore Md 1 X Yes 2 No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be n Funeral 21229 U.S.A. Rock Glen Rd N. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc 1 Never Married 2 Married و 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private 12th Laborer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 18. Mother's Name (First, Middle, Majden Surname)
Mary Lou Taylor 17. Father's Name (First, Middle, Last) 0 Archie Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 16025 Hayes Lane Woodbridge Va 221 19a. Informant's Name/Relationship (Type, Print) 16025 Hayes Lane Kathleen Barnett Daughter| Baltimore, 20a. Method of Disposition Date 2012 20c. Location - City or Town, State 20b. Place of Disposition (Name of Quantico Vet Cem 1 ₺ Burial 2 ☐ Cremation Aug 30 4 Donation 5 Other (Spec Ouantico Va 22. Name and Address of Facility McLaughlin Funeral Home 20020 21. Signature of Funeral Servi 2518 Pennsylvania Ave SE Washington DC ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failure. List Immediate Cause (Final Physician/ Due to (or as a c.) sequence o Artenoaleratio disease or condition resulting in death) 10non Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dise to (or as a nunsequence of) Examir attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical I I I A  $M \le \mathcal{LE} \mathcal{RoU}$ Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the a should be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed completely filled in by the funeral director, page 2 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ပ ER/Outpatient 3 DOA 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation M 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gretifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28

Registrar's Signa

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Maryla	and / Dep	oartmer ertificat			and M	/lental Hy	_	20	12	271.71	
			Registrar     Decedent's Nam	e (First, Middle, L	.ast)				e or L	Calif		2. Date of De	Reg. N	0.20	12	3. Time of Death	<u>ر</u>
	Physicia Medi		WILBERT LL	OYD WEESE								Month AUGUST	25, <sup>D</sup>	2012	Year	11:30 A M	
4	Examir		4a. Facility Name (if	not institution, gi	ive street and num	ber)		4b. City,	Town, or	Location	of Death			c. County	of Death		_
			STELLA MAR					TIMO					E	BALTIMO	ORE		
	Funeral Director	•	5. Social Security N 219.50.744			7. Age (In yrs	s. last birthday,	If Unde Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da			<ol><li>Birthp Count</li></ol>	lace (State or Foreign try)	
			Usual Residence	of Decedent	1 XXM 2 □ F	$\epsilon$	Yrs.					JUNE 5,	1947	,		MD	
	/land f sho	후	10a. State	10b. County		10c.	City, Town or L	ocation							10	0d. Inside City Limits	
	Man 28a-	jë.	MD	ANNE ARL	JNDEL	GLE	N BURNIE									1 ☐ Yes 2XX No	j
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			23a. Part 1 Enter the shock, or hear	he disease, or do t failure. List ody	mplications that ca	aused the de	ath. Do not en	ter the mod	e of dying	, such as	cardiac o	r respiratory ar	rest,			Approximate Interval Between	
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io	ttendi death. tor: A the f	Certificate:	2 Accident 3 Suicide	Investigation	he T			М	1 🗆 1	∕es 2□							
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2		ysician: To the be	of examinati	on and/or inves	stigation in r	ny opinior	n death or	curred at t	the time date a	nd place	and due t	o the caus	ea(c) and manner etator	_
	o the vithin 2 o the		only one) 3 29b. Signature and t	A Certifying Nu	rse Practitioner:	To the best of	my knowledge	, death occu	rred at th	e time, dat	te and plac	ce, and due to t	he cause	e(s) and ma	nner as sta	ated.	_
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10			30. Name and addre	•		,	, , ,, ,	,	)				0	1-11			_
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10a-f, per 1NF, 8934 12-21-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar 27476 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 20, Day 2012 Year Physician/ 12:10 AM Whittington T.ee Bruce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth **Funeral** (Month, Day, Year, Director 232-74-9001 1 ፟M M 2 □ F May 6, 1947 Ohio Usual Residence of Decedent 10c. City, Town or Location Charlotte shov 10d. Inside City Limits Ob. County Mecklenburg be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Silver Spring Yes 2 K No Montgomery NC <sup>10f. Zip Code</sup> **28205** 10e. Street and Number 1900 Townsend Ave. 10g. Citizen of What Country? Funeral 20902 U.S.A. 1131 University Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11 Marital Status Black White etc 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 🕅 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) TRS Technology Information Spec. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Melvin Whittington Marilyn Stivason permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17362 Cannon Mills Road, East Liverpool, Ohio 43920 Patricia Kalinski - Sister 20b. Place of Disposition (Name of Locusting Prother place)
Cousting Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Cremation 3 🖾 Removal from State 8-25-2012 Chester, WV 5 Other (Specify) onation Signeture of Funeral Service Lice Lee Me Paro የዕለዊ can Farlyneral Service 5517 Vine St., Alexandria, VA 22310 lun 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Marked Hypoxemia Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Cause (Disease or injury SVC Syndrome Sir IVC filter use as the burial-trans that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.A -Fib, COPD, Dm Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 X No death? after death.

Director: After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Hospital Other: 2X No Certificate: To 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

6 hr

State Registrar Majid Ra

lania

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D66372

August 20, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2 Date of Death Physician/ Medical Examiner sility Name (if not institution, give street and number Town or Location of Death Birthplace (State or Foreign Country)
 North Carolina **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Director** 1 ÅM 2 □ F 217-30-4391 04/26/1935 Usual Residence of Dece 28a-f show 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD **Baltimore** Reisterstown 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 12020 Reisterstown Road 21136 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ≥ 1 Never Married 2 Married 1 ☐ Yes 2 📈 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry المالية. معلم Hygiene. معد المعلم ال (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unkn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Albert Wilson 1 and 2 should be of Health and Meitem 27 is mark Mary Coward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andre Wilson / Son 2498 Silva Court, Manchester, MD 21102 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 8/26/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical Box 68760 IF FEMALE: nse f yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ō in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ed by the a 9 Unknown P.O. s been signed by t 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autonsy certificate 2 No Yes 1 Yes **Division of Vital** filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury s after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is my contained. Medical 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ath (Item 23a) (Type, Print) who complete Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ illiam Wetze 10:10 AM 2012 Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of Dis... (Month, Day, Year, **Funeral** Months Days Director 1 MM 2 □ F 219-10-0245 Maryland Usual Residence of Decedent ortent: If item 27 is marked other then "natural", or items 23a or 28e-f show Injury or other traumatic event, the <u>Medicel Examiner must be notified at</u> 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 United States 1806 Wilson Pt. Rd 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Uhite metzelberger, William 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene.
7 is marked other then Elementary/Secondary (0-12) College (1-4 or 5+) 12 Meat Meat Cutter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Importent: If item 27 is marke eny Injury or other traumatic v William Wetzelberger Sr. Jeanette Peters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine Wetzelberger /Wife 1806 Wilson Pt. Rd. Middle River, MD 21220 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Aug 25 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2012 Chesapeake Cremator 21. Signature of Funeral Service Licensee 22. Nacceedad Ton Fail Funeral Alternatives Kelbeccer Abo 8717 Green Pastures Drive Towson Maryland 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 SS IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death ed by the a detached f 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Natural
Accident
Suicide
Homicide 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifie 29d. Date signed (Month) D31180 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MD MININS MICHAEL 31. Date filed (Month, Day, Year) State 2 AUG Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			amend #205 For State Registrar	atë di™Marÿhand Æ	Dépar <del>t Nea</del> t อ#เ Certificate of L			no. 2012	27479
	Physicia	n/	Decedent's Name (First, Middle, Last)	1 111	1500		2. Date of Death Month	Day Year	3. Time of Death /0:15 / M
	Medic Examin		Leonard Ho  4a. Facility Name (if not institution, give street a	nd number)	4b. City, Town, or	Location of Death	August:	4c. County of Death	70.757
تمعب	Funeral	100	5. Social Security Number 6. Sex			If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Director		5. Social Security Number  242-44-5836  1 M 2  Usual Residence of Decedent	81	Yrs. Months Days	Hours Min.	1 / 22 / 3 1	nr) Coun	"NC
	ryland -f show ied at	ctor	10a. State 10b. County N/A	10c. City, Town	or Location imore				0d. Inside City Limits 1   Yes 2 □ No
	vith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number 2816 W. Mosher St		10f. Zip Code 2121	6	10g.	Citizen of What Coul	
036	ould be filed within 72 hours after death with the Maryland Ind Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married Ar	as Decedent Ever in U.S. med Forces? Yes 2 X No (es, Give ar or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1  Yes 2 X No	in, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - America Black, White, Africar Specify: Ame	etc. 1
Baltimore, Maryland 21215-0036	hin 72 hour ne. than "natu ie Medical	Completed	15. Decedent's Education (Specify only highest grade contemporary/Seconday (0-12)		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired) Driver		ng	Kind of Business In	dustry
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Mary	d 2 should alth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Type, Pri Christine Wilson/	Wife 2	. Mailing Address (Street & 816 W . Mos	and Number or Rura sher St.	Route Number, City , Balt., N	v or Town, State, Zip ( MD 21216	Code)
Imore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Remov  4 □ Donation 5 □ Other (Specify)	val from State 20b. Place of cemeter Mt.	f Disposition (Name of ry, crematory or other place Zion Cem.	ee) 8/27	hate 200 /12 Ba	alt., MD	own, State
Balt	permit. Departi		21. Signature of Funer I Service Lice see		22. Name and Address 5126 Bela	ss of FacilityHar air Rd,B	i P. Clo	21206-5	05 <sup>PA</sup>
	Ph, ician Medical Examiner	76.50	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do not be on each line.  However, the consequence of the conseq	5/80	g, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
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0	cate be executed physician and sthe burial-transit	dical Exa	that initiated events C. —	Due to (or as a consequence of	of):				
. Box 68760	death certifi ne attending ed for use as	Completed by Physician/Med	in the past 12 months?	yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death ☐ Pregnant at time of death ☐ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ру		23d. Date of deliv	ery Day Year
ls, P.O	uires that the signed by ald be detact	ed by Pł	Part II. Other significant conditions contribut	ing to death but not resulting i	n the underlying cause giv	ven in Part I.		co use contribute to t	ř
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach	Complet					24a. Was an autopsy performed	prior to co	psy findings available impletion of cause of
/Ital	sician: certific irector,	Be	25. Was case referred to medical examiner?  1 M Yes 2 No  Hospita	al: 1 ☐ Inpatient 2 ☑ ER/Ou	Oth	er:		e 6 🗆 Other (Specifi	Α.
n of \	ding Phy h. After this funeral c	sate: To	1 ☑ Natural 5 ☐ Pending	a. Date of injury 28b. 7	Firme of 28c. Injury work	y at	28d. Describe how in		
IVISIO	l or Atten after deat Director:	Certificate:	3 Suicide 6 Could not be	e. Place of Injury - At home, fa building, etc. (Specify)			28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
_	ne Hospita in 24 hours ne Funeral pleted fillec	Medical	(Check 2 Medical Examiner: Or	To the best of my knowledge, the basis of examination and/o tioner: To the best of my know	or investigation, in my opinio	on, death occurred at	the time, date and pl	lace, and due to the ca	use(s) and manner stated.
	To the within to the complex c		29b. Signature and Me of certifier	MP	29c. Licenso	e number 3 7 7	29d. 8	Date signed (Month,	Day, Year) 12
	HV		Christopher Bado	ed cause of death (Item 23a)	aiden Co	hoice L	ane Ba	Itimore/	11021228
	Sta Registr		31. Date filed (Month Pay 2 8 2012	2. Registrar's Signature	parker				

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Wooner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 15, 2012 Winberta M. Yan 8:44 A MMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery . Social Security Number Birthplace (State or Foreign Country) . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 067-30-7219 Director 1 🗆 M 2 🗓 F December 10, 1924 California 87 show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director D.C. Washington 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral 3001 Veazey Terrace, NW Apt.325 20008 United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Midowed 4 □ Divorced Asian Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Librarian University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 N. Wing Mah Bertha Hosang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wynette Yao /Daughter 5411 Roosevelt Street, Bethesda, Maryland 20817 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State August 22 Department of Important: If it any injury or o cemetery, crematory or other place) Cerrito, E1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset View Cemetery 2012 California 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie Robert A. Fumphrey Funeral Home/Bethesda-ChevyChase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Inc. M01305 MALL 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Promiciani Respiratory Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Chronic Obstructive Pulmonary Disease Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examir Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Pregnant at time of death Month Day Year signed by the at Id be detached for g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 X No ည 1 Inpatient 2 X ER/Outpatient 3 IDOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation

Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifics upletely filled in by the funeral director, within 2

To the I

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Todd Andrew Templeman, M.D.

6 Could not be

determined

D69 117

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 0 115 112

28f. Location (Street and Number or Rural Route Number

City or Town, State)

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

8600 Old Georgetown Road, Bethesda, Maryland 20814

31. Date filed (Month, Day, Year)

Suicide

4 Homicide

29a. Certifier

(Check

only one 29b. Signature and title of

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

engenon

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a7b Per PHY G932 10/26/2012 JH tate of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elizabeth L. Zachos 7:17 PM August Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. (Month, Day, Year) Director 216-48-0484 1 □ M 2 🔀 F 67 April 29 1945 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at ORCE. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10632 Anglohill Road 21030 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married ۾ ☐ Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Counselor Bereavement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Elizabeth A. Gronaw Coy Evan Vance, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spiro S. Zachos/ Husband Anglohill Rd. Cockeysville, MD. 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD. Pk. 8-28-12 View Mem. <sup>22. Name and Address of Facility</sup>. Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Brain Damage due to Complications of Radiation Interval Between Onset and Death Immediate Cause (Final JUTUSTA Yea St Physician/ Therapy disease or condition Medical resulting in death) Examiner Treatment of Metastatic Breast Cancer to Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death certificate has been signed by the a lirector, page 2 should be detached 1 ☐ Yes ∠ v q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autops death? 1 Yes 2 LIN 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Hospital s after death.
al Director: After this comment in by the funeral director. ျ 1 Yes 2 AK 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 ☐ Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bulthweekb 212cs 41.05 Pat 6701 Cha 2 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Atkinson Wayne Month 1304 PM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death University of Maryland Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) **Director** 212-64-1677 Usual Residence of Dece 1 🗶 M 2 🗆 F sidence of Decedent 58 03-08-1954 <u>Maryland</u> 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Funeral Director 10d. Inside City Limits be notified 1 🗌 Yes 2 💢 No MD Calvert Huntingtown or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 5751 Stephen Reid Road 20639 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give Completed 3 Divorced Specify: Year or Dates White ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the N Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sheet Metal Worker Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leslie Campbell Atkinson Willie Murl Atkinson 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 2 Deborah J. Atkinson, Sister 5751 Stephen Reid Rd., Huntingtown, MD 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State i i Department of Important: If any injury or 4 Donation 5 Other (Specify) Metropolitan Crematory 8/9/2012 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. MO0715 8325 Mt. Harmony Lane, Owings, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) robable Physician/ menimitis Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Completed 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 1 Yes been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Hospital or Attending Physician: The law After this certificate has autopsy 1 Yes 2 No Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 🗌 No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month. Day, Year)

ARW 15

State 31. Date filed (Month, Day, Year)
Registrar AUG 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oanya Khoujah, 22 S Greene St. Boutimare MD 21201

31. Date filled (Month, Day, Year)

32. Registray's Signature

Mesident Physician

B. Saves

1659682995

8/6/12

		For State Registrar				and / De		nt of H	lealth		All Copie Mental Hy	giene Reg. No.	0.0	12	27484
Physicia Medic		Decedent's Name (First, Theresa Mae	Bryant								2. Date of De August		2012	<b>/</b> ear	3. Time of Death 9:14 a. M
Examin	er	4a. Facility Name (if not ins 2 Greenwood		reet and nun	nber)			Town, or lian 1	Location Head	of Death		4c.	County of Char		
Funeral Director		5. Social Security Number  577–46–5478  Usual Residence of Dece		м 2 <b>Х</b> ғ	7. Age (In yi	rs. <i>last birthda</i> j Yrs.	/) If Under Months	Pr 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 14	y, Year)		Count	olace (State or Foreign try) ngton D.C.
e Maryland 28a-f shov notified at	Director	10a. State 10b. Maryland	County Charle	s	10c.	City, Town or Indian	n Head								0d. Inside City Limits  1 XYes 2 No
s 23a or ust be	Funeral I	10e. Street and Number  2 Greenwood	Place					0640				10g. Cit	U.S		try?
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status  1  Never Married 2  3  Widowed 4 D	☐ Married	Armed Fo	<sub>/e</sub> X No	U.S. 13	3. Was Dece If Yes, spe 1  Yes	cify Cuba	n, Mexica	n, Puerto	ecify Yes or No- Rican, etc.)			America White, e	etc.
ithin 72 hou ene. r <b>than "natu</b> t <b>he Medical</b>	Completed		Decedent's Edu ly highest grade (0-12)			(Giv	cedent's Usu ve kind of wo DO NOT us cretar	ork done d e retired)	ation during mos	st of work	ing		ind of Busi		ernment
ld be filed w Mental Hygi larked othe atic event, i	To Be	17. Father's Name (First, N		urtin							e (First, Middle, arie Smi	Maiden S			
d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Re Kathleen M.			Daught						al Route Numbe ndian He				
Page 1 an ment of He tant: If iten lury or oth		20a. Method of Disposition  1 Burial 2 Cre 4 Donation 5 0	mation 3 $\square$ R	emoval from	State	b. Place of Dis cemetery, c. aryland	rematory or	other plag	Aug. Ceme	16, etery	<sup>□</sup> 2 <sup>†</sup> 012 7		cation - C		wn, State Maryland
permit Depart Impor any in		21. Signature of Funeral S	rice License	-	МО	0668	₩1111 4270	ams Hawtl	Funer horne	al F	Home, P.	A. an He	ead, 1	Md	20640
Physician/ Medical Examiner		23a. Part 1. Enter the bise shock or heart failur Immediate Rause Final disease or condition resulting in death)	ease, or compli e. List only one	D cause on ea	ech line.	leath. Do not e	nter the mod	de of dying		cardiac	or respiratory ar		ود. ()	1	Approximate Interval Between Onset and Death
be executed sician and burial-transit	Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events	s, te b		(or as a cons	sequence of):	<u> </u>	K (	100	7	<del>9</del> 8			#	
cate be exe physician a s the burial.	<u>ज</u>	resulting in death) Last	L		(Or as a cons	sequence oi).									
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	alli	1 🔲 Live	tcome of pre Birth 2  l Inant at time nown	Fetal death 3	B		ey			:	23d. Date Montl		ery Day Year
equires that the sen signed by the could be detailed by the details and the details and the could be detailed by the second seco		Part II. Other significant of	conditions con	tributing to c	death but not	resulting in the	e underlying	cause giv	en in Part	1.					e cause of death?
rsician: The law re s certificate has bu director, page 2 st	Completed by	25. Was case referred to m	nedical					os Die	and of Don	oth (Choo	24a. Was auto perfo 1 \sum Yes	psy ormed?	pri de:	or to con ath?	osy findings available mpletion of cause of
Physicia this cert ral direct	: To Be	examiner? 1 Yes 2 No 27. Manner of Death	_	ospital: 1		☐ ER/Outpat		Othe	er: 4 🗆 N		ome 5 🔀 Resi			(Specify)	
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	Certificate:	1 Natural 5 2 Accident	Pending Investigation Could not be determined	(Mon 28e. Place	th, Day, Year	injury t home, farm, :	M		? Yes 2 [	] No	28d. Describe h	Street and		or Rural	Route Number,
ospital o hours afi ineral Di ly filled ir	Medical C			ian: To the b	est of my kn	lowledge, deat					nd due to the c	ause(s) ar			
o the Ho	Med		rtifying Nurse				ge, death oc		he time, da		t the time, date a ace, and due to	the cause		ner as s	
5		· K.	Mall	~			T	138	31	, )		P	-13	3-1	2
By		30. Name and address of	Da	V, 2	1	200	e, Print)	W.	-10	0	rt 1	$\sim$ $\sim$	6 (	06	93
Stat Registra	te ar	31. Date filed (Month, Day AUG	1 3 201	2 32.4	legistrar's Sig	enature.	back	•							

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			1 - State of Ma State Registrar	ryland / Depa <i>Cel</i>	artment of H rtificate of D	ealth and N <i>eath</i>	lental Hyg/ R	iene eg. No.	12	27485
i	Physicia		1. Decedent's Name (First, Middle, Last)  Juanita S. Bolden				2. Date of Deat Month Aug 9,	h _	Year	3. Time of Death 3:26 A M
~ ~	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of	of Death	3.20 H
			Southern Maryland Hospital		Clint					George's
	Funeral Director		5. Social Security Number 579 52 4984  Usual Residence of Decedent	(In yrs. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/23/	Year)	Country	ace (State or Foreign y) ington DC
	land f shov	tor		10c. City, Town or Lo	cation				10	d. Inside City Limits
	Many 28a-	Director	Maryland Prince George's	Brand	lywine	<u> </u>				1 ☐ Yes 2X No
	ith the	ral	10e. Street and Number  13816 Tower Road		10f. Zip Code 20613			10g. Citizen of W <b>United</b>		
	eath v	Funeral	11 Marital Status 12. Was Decedent Ev	er in U.S. 13.	Was Decedent of His	panic Origin? (Spe	ecify Yes or No-	14. Race	- America	n Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 XXWidowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 XX N If Yes, Give Year or Dates.	0	If Yes, specify Cuban	Specify:	Rican, etc.)	Black Specify:	, White, et	
5-0	72 hou "natu edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done du	tion uring most of worki	ng	16b. Kind of Bus	iness/Indu	ustry
12	nould be filed within 72 nd Mental Hygiene. s marked other than " umatic event, the Mec	Con	Elementary/Secondary (0-12) College (1-4 or 5+	) [	O NOT use retired)  yroll Clerk			Dept HH	5	
pu	filed wall Hygard A othe	Be	17. Father's Name (First, Middle, Last)		<u> </u>	18. Mother's Name	e (First, Middle, N			
ylaı	uld be Ment narked natic e	욘	Leroy Simmons			Luci	11e Hamm			
Maryland	12 should be file lith and Mental H 27 is marked o r traumatic eve	10	19a. Informant's Name/Relationship (Type, Print) Sylvia A. Walker (Daughter)	- L	ng Address (Street ar			-		nde)
	of Health of Health fitem 27 rother tr		20a. Method of Disposition	20b. Place of Dispo	09 Trumbull sition (Name of			20c. Location - 0		n, State
altimore,	Page ment o ant: If ury or		1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	matory or other place lemorial Ceme	i	7/2012 I	Waldorf, N	n	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	101555 22	2. Name and Address	of Facility Lee	Funeral H			ld Alexandria
	40 = e 0		23a. Pan 1. Enter the disease, or complications that caused t	57   F	<u>'erry Road, (</u>	Clinton, M	) 20735		-	Approximate
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Atheros	scleratic	Coron	A CIO	1+115		interval Between Onset and Death
1	Medical Examiner		disease or condition resulting in death)  a.   Due to (or as a condition or as a con	consequence of):				Dism	7	
		iner	Sequentially list conditions, if any looking to an involute cause. Enter Underlying	ourseque de uty					1	
	sate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c.	consequence of):					$\perp$	
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3760	ficate g physas the		a							
Box 687	h certi tendin or use	lan/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of	Fetal death 3	Ectopic pregnancy	,			of deliver	
В0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transi	Physician/M	1   Yes 2 N No 9 Unknown 9 Unknown	time of death 5	Other (specify)			Mon	tn L	Day Year
P.0	that th ned by e detac	by Ph	Part II. Other significant conditions contributing to death but	t not resulting in the u	ınderlying cause give	en in Part I.	23e. Did tob	acco use contrib	oute to the	cause of death?
ds,	requires been sign should be						1 □ Y€	es 2 🗆 No 🤇	3 🗌 Proba	ibly 4 🗓 Unknown
Vital Records, P.O.	law red nas ber e 2 sho	Completed					24a. Was ar autops	sy / pr	ior to com	sy findings available pletion of cause of
æ	sician: The law scrifticate has k		25. Was case referred to medical				1 Yes		eath?	□ No
Vita	ysicial s certii directo	To Be	examiner? Hospital:	nt 2 ER/Outpatier	_ Other	ce of Death (Check	_	ence 6 🗌 Other	(Specify)	
of	ng Phy ter this		27. Manner of Death  1 M Natural 5 Pending  28a. Date of injury (Month, Day,	28b. Time of		at		w injury occurred		
ion	ttendii death. tor: Al	Certificate:	2 Accident Investigation		M 1 🗆 Y	/es 2 □ No				
Division of	al or Al	- 3	4 Homicide determined 286. Place of Injury building, etc.	y - At home, farm, str (Spec <i>ify)</i>	еет, тастогу, опісе		28f. Location (Sti City or Town	reet and Number , State)	or Hural H	loute Number,
	To the Hospital or Attending Physician: within 24 hours after death and the funeral Director. After this certifical completely filled in by the funeral director,	Medica	29a. Certifier 1 Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner	mination and/or inves	tigation, in my opinior	n, death occurred at	the time, date an	d place, and due	to the caus	e(s) and manner stated.
	o the vithin 2 or the comple	Š	only one) 3 L Certifying Nurse Practitioner: To the l 29b. Signature and title of certifier	best of my knowledge	, death occurred at the 29c. License			e cause(s) and ma 9d. Date signed		
	6		▶ € D N		D6:	4055		08/1		
	m-3		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, F	Print)	0.1	0/2 .	0 0-5	0 41	725
	U al-		Eric D. McDonald 31. Date filed (Month, Day, Year) 32 Registrar'	s Signature /	urratts	Ka.	Jinto!	ains	20	150
	Stat Registra		AUG 1 3 2012 Janua	1. 40	Ked					

State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar 27486 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ August 9, 2012 Year Rose Myrlee Dodd Burtner **12:50** PM Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northampton Manor Nursing Home Frederick Frederick 8. Date of Birth
(Month, Day, Year)
Nov. 11, 1929 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maryland 213-24-8497 **Director** 1 □ M 2 🗶 F 82 Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Frederick Myersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 11924 Woodland Way Road 21773 United States 12. Was Decedent Ever in U.S. Armed Forces 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done duning most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Registered Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Moss Dodd Rosie Masser 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 11924 Woodland Way Drive, Myersville, MD 21773 Brad Burtner / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 13, ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Frederick, Maryland 21. Signature of Funeral Service License Keeney and Basiord PA Funeral Home. 106 E. Church Street, Frederick, MD 21701 M01473 23a. Par 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Congestive Heart Failure Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and id be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 ANo
9 Unknown 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 X No 1 Tes Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 A Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated place, and due to the cause(s) and manner stated place, and due to the cause(s) and manner as stated. 29b. Signature and the certifier 29c. License number 29d. Date signed (Month, Day, Year) D51643 August 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hiren N. Shah, M.D. 65C Thomas Johnson Drive, Frederick, Maryland 21702 31. Date filed (Month, Day, Year) AUG 1 3 2012 32. Registrar's Signature State oake Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Doris C. Brainard Physician/ Montl 2012 August 6:11  $P^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 303 Saddle Ridge Road Annapolis Anne Arundel 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 221-01-5902 Director 1 | M 2 | F | F 93 1919 Yrs May 14, Maryland er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 1957 Marconi Circle 21401 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2X No Black, White, etc. ð 1 Never Married 2 Married 72 hours after White If Yes Give 1 🏻 Yes 24ဩ No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 permit. Page 1 and 2 should to filed w Department of Health and Mental Hyg Important: If item 27 is mar led othe any injury or other traumatil event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Harrison Hall Sara Jane LeGates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Smith/daughter 303 Saddle Ridge Road Annapolis, Maryland 21403 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Saints Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State MX Burial 2 Cremation 3 Removal from State 8/10/2012 Wilmington, Delaware 4 Donation 5 Other (Specify) Signature of Juneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home oud 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Physician/ Congestive Heart Failure disease or condition resulting in death) vear Medical Due to (or as a consequence of) Examiner Hypertension 15 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Exami The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XXNo
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b lirector, page 2 s 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 No al o**r Attending Phys**ician: Th s after death. I **Director:** After this certificat 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Daughter's Home Hospital: 2 X No Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1XXNatural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 24 hours Hospital Medical 29a. Certifier 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17965 August 8, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Friend 116 Defense Highway Annapolis, Maryland 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

21215-0036

Maryland

Box 68760

P.0.

Records,

Division of Vital

32. Pégistrar's Signature

AUG 09 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 0<sup>7</sup>7 ELIZABETH JANE BUCKLER 2012 9:15 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/03/1941 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 218-38-1076 1 M 2X X F Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Jefferson 1 Yes ZXX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4105 Cherry Lane 21755 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. 1 Never Married 2 X Married 2 x No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: White 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Verizon Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Wolfe Henry Ellen Reese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Buckler / Husband Cherry Lane Jefferson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 08/13/2012 Resurrection Cem. Clinton, Maryland 5 Other (Specify) 4 Donation 22. Name and Address of FacilitGeorge P. Kalas Funeral Home PA a 6160 Oxon Hill Rd. Oxon Hill, Maryland 23a had 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Interval Between Onset and Death Immediate Cause (Final STOK disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year 21 No Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 26. Place of Death (Check only one)

Physician/ Medical Examiner or Attending Physician: The law requires that the death certificate be executed

and

attending

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Director: After

Department of H
Important: If ite
any injury or otl
once.

Physician/

Examiner

**Funeral** 

Director

28a-f shov

oms 23a or 28a-f sh r must be notified a

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Medical

10a. State

Director

Funeral

Completed by

Be

2

21. Signatu

-trar burialphysician s the burial as nse for certificate has been signed by irector, page 2 should be detac filled in by the funeral director,

Exami Physician/Medical Be Completed by 2

Certificate: Medical

To the Hospital within 24 hours a To the Funeral C State

Hospital

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2\[9 Unknown 25. Was case referred to medical examiner? 1 Tes 2 No 27. Manner of Death Natural
Accident
Suicide 5 Pending Investigation

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28a. Date of injury (Month, Day, Year)

Other:

1 Yes 2 No

28c. Injury at

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Nursing Home 5 Residence 6 Other (Specify,

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospita

AUG 09 2012

29b. Signature and title of certifier

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 27489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary Elizabeth Gibson Blanchard 2012 August 7:33 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Safe Haven Manor Sudlersville Queen Anne Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Days Hours Min. (Month, Day, Year) b 19, 1919 **Director** 93 Maryland 220-01-3189 Feb Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits 1 Tes 2 No Maryland Queen Anne Barclay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 514 Barclay Road 21607 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress clothing industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thompson E. Gibson Edith Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paige Kingsbury/ niece 514 Braclay Road; Barclay, Maryland 21607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Saints Cemetery Aug 21, 2012 Wilmington, Delaware 22. Name and Address of Facility PO Box 160; Greensboro, MD 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funéral Home, PÁ; 21639 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Failure to disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ROFOURd Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine signed by the attending physician and deed detached for use as the burial-transit death certificate be executed TV a N Ced that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 2 No Yes Hospital or Attending Physician: The law requires that the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by BiLatual KNEL ANTHRITIE Division of Vital Records, cate has been si Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific, completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 孋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar H184

223

. Registrar's Signature

123880

Street, CHeckertown, Hed 219 20

auna

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRABAL TR, MO.

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			Registrar  1. Decedent's Name (First, Middle,	Last)		007	- Care	oi Dea		2. Date of Dea	Reg. No:	-	3. Time of Death
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	20000		12195 Greensbo	ro Road			-	nsbor				coline	
Fund	eral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 \	Year If U	Jnder 24 Hrs.	8. Date of Birt	h	g Birth	place (State or Foreign
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ems	n u	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.		Vas Decedent	t of Hispani	ic Origin? (Spe	cify Yes or No-		Race - Americ	an Indian.
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Hygi w	ent,	å	17. Father's Name (First, Middle, L	ast)		Home	marci	18.	Mother's Name	e (First, Middle,			
Mal ylallo 12 should be filed lith and Mental Hy 27 is marked oth	tic ev	잍	Frank Breeding					Sa	arah Pe	arson			
Vidity 2 should th and N	numa		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailin	g Address (S	treet and N	lumber or Rura	l Route Numbe	r, City or Tow	n, State, Zip (	Code)
and 2 s Health em 27	er tra		Virginia Jones,	daughte	er	1277	O Ridg	gely R	Road; G	reensbo	ro, Ma	ryland	1 21639
e ± e G	r of		20a. Method of Disposition 1 XBurial 2 ☐ Cremation	3 Removal from		Place of Dispo				Date	20c. Locati	on - City or To	own, State
t. Page 1 tment of tant: If it	jury		4 Donation 5 Other (S	pecify)		ensbor							Maryland
partiffice, Mal yially 21213-0030 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show	any in		21. Signature of Funeral Service L	icensee		F1	. Name and A $\mathbf{eegle}$	and H	<sup>Facility</sup> PO Helfenb	Box 160 ein Fun	; Gree	ensboro Home, H	, Maryland PA; 21639
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that	caused the dear	th. Do not ente	r the mode o	f dying, suc	ch as cardiac c	or respiratory are	rest,		Approximate
Physic	ian/	ļ	Immediate Cause (Final disease or condition	CA	DIA	· 71	NOT DE	TIV	TAL	1			Interval Between Onset and Death
Med Exam	_		resulting in death)		(or as a conseq	,	1001	110	1.14	7			TCU1CE
LAGIII		۱ ۾	Sequentially list conditions,		121050		ic c	APD	PAUDA	CULAR	Dise	ASC (	Chronic
ъ :	sit	<u> </u>	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	(or as a conseq	uence of):							
xecution and	ıl-tran	Еха	that initiated events resulting in death) Last	c	(or as a conseq	uence of):							
te be e	pontis	dical Examiner		L <sub>a</sub>									
ficate g phy	as the	Med	C CCMALC										
certific	nse	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy aldeath 3	Ectonic pred	anancv			23d	. Date of deliv	ery
death he atter	ed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ๋ No 9 ☐ Unknown		gnant at time of		Other (spec					Month	Day Year
the strine	etach		Part II. Other significant condition	ns contributing to	death but not re	sulting in the u	nderlying cau	ise diven in	Part I	220 Did to	nhaana uga s	antributa to t	he cause of death?
S, F.O. BUX 00/00 res that the death certificate be executed signed by the attending physician and	p e d	Completed by		15/20	DEV	WEXK	TA	311 e 11 11 11 11 11 11 11 11 11 11 11 11			-		bably 4 Unknown
e law requires	should	ete	11611	(0)	4	. 40 14			<del></del>	24a. Was			psy findings available
e law	ge 2 s	dmc								autor perfo	osy orm <u>e</u> d?	prior to co death?	mpletion of cause of
r ii iii	or, pa		25. Was case referred to medical			-		26 Place o	of Death (Check	1 Yes	2 No	1 Yes	2   No N//
ysician s certifi	direct	10 B	examiner?  1 S Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier		Other:		me 5 <b>a</b> Resid	tence 6 🗆	Other (Specific	4
o Page Page of the thing of the	neral		27. Manner of Death	28a. Date		28b. Time of injury		Injury at work?		28d. Describe h			
endir eath. or: Af	he fu	ilica	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	gation		,,	М	1  Yes	2 🗌 No				
al or Attendi s after death.	in by	Certificate:	4 Homicide determ	inad 28e. Place	e of Injury - At h ling, etc. <i>(Specif</i>	ome, farm, stre	eet, factory, o	ffice		28f. Location (S City or Tow		mber or Rura	Route Number,
spital spital	illed	edical	29a. Certifier 1 Certifying	Physician: To the	best of my know	/ledge, death o	occured at the	e time, date	e and place, an	d due to the ca	use(s) and m	anner as state	ed.
DIVISION OI VITAL RECORDS, F.O. BOX 00/00. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and	npletec	Med	only one) 3 Certifying	xaminer: On the ba Nurse Practioner									use(s) and manner stated. ated.
Noit To t	COL		29b. Signature and title of certifier	B		MA	29c. Li	icense num	//L		29d. Date si	gned (Month,	Day, Year)
			Wirstlau	J HM	HU/	110	<u> </u>	146	67		08/	12/2	0/2
			30. Name and address of person of the second	NWDI	se of death (Iter	(810)	DEN	ON	MO:	2162	9		
Reg	Stat gistra		31. Date filed (Month, Day, Year)	1 4 20 2	Registrar's Signa	ature	done						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G931 9/20/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4 19, 2012 Allen 240 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frostburg Allegany Frosburg Village Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country

A Funeral Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 1 X M 2 - F Oct 6. 1927 **Director** 212-24-1048 84 28a-f shov 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Funeral Director MD Allegany Frostburg 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Kaylor Circle 21532 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No "natural", Specify: Completed 3 X Widowed 4 Divorced WWII white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. the 12 **CSX** Transportation electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maude Estelle Donahoe Department of Health and Ment Important: If item 27 is marke any injury or other traumatic James Cleveland Bridges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 54 New Hampshire Ave Cumberland Diane Crippen MD 21502 daughter 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 20c. Location - City or Town, State Rocky Gap Veterans Cemetery 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 8/22/2012 MD **Flintstone** 4 Denation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA Signature Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition days resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been sig 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Seluring Home 5 Residence 6 Other (Specify, 2/1 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) V21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

AUG 28 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 Physician/ 130PM RONALD BURK SR. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Days Hours Min. 212-52-7277 Director 1 **X** M 2 □ F 58 Usual Residence of Decedent 8/20/1953 Maryland 28a-f show 10a. State 10b County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Tes 2 No PA. Tork Airville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a 364 East Posey Road 17302 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ★ Yes 2 □ No
If Yes, Give ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced If Yes, Give Year or Dates. Vietnam White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 al Hygiene. d other than " College (1-4 or 5+) Elementary/Secondary (0-12) Automobile Seats Maintenance Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8m382438 and Mental I ပ Burk Ells Harold Ross Blanche Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traus (Son) Johnathan Burk Frans Drive Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem. Jarrettsville, MD. 21. Signature of Funerat Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville. Maryland Home Part 1 Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph. sici\_n/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** DISGASE STAGE RENDL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury WON SURGICAL PEMPHENAL VASUNAR DISCARE and that initiated events resulting in death) Last physician a s the burial-Physician/Medical 68760 IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant Box ( 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death Month Year 2 No 1 Yes 2 L 9 Unknown 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Yes Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred or Attending (Month, Day, Year) 5 Pending Director: A 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined building, etc. (Specify) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License numbe D26191 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. ANUSHA. SIRITHANA, 260, GATEWAY OR IVE, SMITE 21/22B, BETAIR, MD 21014

Registrar DHMH 17 Rev 06-2011

State

D. ANUSHA. SIRITHORD,

31. Date filed (Month, Day, Year)

RONALD

32. Registrar's Signature

			For State Registrar	State o	f Marylan		artment of F rtificate of				jiene leg. No. /	2012	2749	3
			Decedent's Name (First, Middle	e, Last)						2. Date of Dea	th	_ 0 ; L	3. Time of Death	_
	Physici /Medio		Maurice	Trittipo	e C	ompher				August	$11^{Day}$	2012	7:30 a	Λ
4	Examin		4a. Facility Name (If not institution	-	mber)		4b. City, Town, o		n of Death		4c. C	County of Death		
. to			9209 Sam Owing				Ow:	ings	er 24 Hrs.	O Data of Dist		Calver		
L	Funeral Director		5. Social Security Number 224-32-1742	6, Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. 8		Months Days	Hours		8. Date of Birth (Month, Day 10/15/1	927	Virg	place (State or Forel ntry) inia	gn —
	w and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limit	s
	Maryl:	Ď		e George'	s Ri	verda1	e						1 X Yes 2 □ N	0
	r 28a	Funeral Director	10e. Street and Number	e dedige	O KI	VCI 442	10f. Zip Code				10g. Citiz	en of What Cour	ntry?	
	h with	a D	4813 Madison	Street			20	737				U.S.A.		
	ems.	iner	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of I	Hispanic (	Origin? (Spean, Puerto	ecify Yes or No- Rican, etc.)	1-	4. Race - Americ Black, White,		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is Michael Ever intering a notified at		1 ☐ Never Married 2 ☐ Mar 3 💢 Widowed 4 ☐ Divorced	ried 1 ☐ Yes If Yes. G	2 <b>X</b> ]No ive		1 □Yes 2 <b>X</b> □No					Specify: wh		
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121	led w Hygiel her ti		12 17. Father's Name (First, Middle,	I get)		CT	erk	18 Mo	ther's Name	e (First, Middle,		lity co	прану	
Maryland	2 should be fil and Mental H is marked otl raumatic ever	To Be	,	lliam	Compher			Mai		Elizat		· _	ttipoe	
ary	shou and N s mar		19a. Informant's Name/Relations	ship (Type. Print)	<del>-</del>	1	ng Address (Street						Code)	
	and 2 ealth a m 27 is		Kevin A. Compl	ner, son			Sam Owi							
Baltimore,	ges 1 t of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from			sition (Name of natory or other pla		1	Date		cation - City or To		
ţi	t. Pag tmen tant; njury		4 □ Donation 5 □ Other (S	Specify	Met		tan Crem					exandria	<u> </u>	
Bal	permit. Pages 1 an Department of Heal Important; If item 2 any injury or other once.		21. Signature of Funeral Service	licersee	ncell	I .	2. Name and Address 325 Mt.						Р.А. 736	
			23a. Part 1. Enter the disease, of shock, or heart ailure. Lis	r complications that	caused the deat	h. Do not en	ter the mode of dy	ing, such	as cardiac	or respiratory ar	rest,		Approximate Interval Between	
- Carlot	Physician		Immediate Caus Pinal disease or condition	. Me	1 -1	tre	colon	00	MC	29			Onset and Death	
	/Medical Examiner		resulting in death)	Due to	(or as a conseq	ue ice of):								
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	uted I Insit	Examiner	Sequentially list conditions, if a year is a condition cause. Enter Underlying Cause (Disease or injury	<	(5) 40 4 5) 100 4	00100								
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9	ertifica ing ph e as th	Med	IF FEMALE:	1			-				-1			
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 🗆 Live	tcome of pregna birth 2 Feta	death 3	Ectopic pregnan	ю			2	3d. Date of delive Month	ery Day Year	
Ö	he de / the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unk	gnant at time of on nown	ieain 5	Other (specify)							
σ.	res that the de signed by the a lbe detached l		Part II. Other significant condit	ons contributing to	death but not res	ulting in the u	nderlying cause gi	iven in Pa	rt I.	23e. Did to	obacco us	se contribute to	the cause of death?	
rds	quires n sigr ald be	d by	Type 2 di	befes v	nellite	15				1 🗆 Y	es 2 🎾	No 3□ Pro	bably 4 🗌 Unknow	νn
of Vital Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed								24a. Was	SV	prior to co	opsy findings availat ompletion of cause o	ole of
E H	ding Physician: The In. After this certificate hufuneral director, page	Con								1 □ Yes	rmed? 2 No	death? 1 ☐ Yes	2 🗆 No	
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of	Phys r this ral dii	<u>ا۔</u>	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2  of Injury	ER/Outpatie	nt 3 DOA	4 🗆	Nursing Ho	ome 5 Residence Residence Residence 28d. Describe Residence		Other (Spec	resid	<u>~</u>
on	ding th. : Afte e fune	tiol	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Mo. igation	nth, Day, Year)	Injury		ork? ⊒Yes 2	□No					
Division	or Attendafter death Director;	Certification: To	3 Suicide 6 Could 4 Homicide deter	not be mined 28e. Place build	e of Injury - At h	ome, farm, st	reet, factory, office			28f. Location (S City or Tov			al Route Number,	
	urs af		OO- O-William 4 M O-William	la a Dhuaisian. Ta th			th appropried at the	time deta	and place	and due to the	001100(0)	and manner ac	etated	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, is	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ng Physician: To th I Examiner: On the and ma	basis of examination	ation and/or i	nvestigation, in my	opinion,	death occur	rred at the time,	date and	place, and due	to the cause(s)	
	Vithi To th	Ř	29b Signature and title of certifi	er 1			29c. Licen	ise numb	er .			e signed (Month		
			- May ()	Wells	1)		DI	1321	4		13	saug	2012	
10	n) A		30. Name and addrest of person	who completed cau		4		D		e Free		L WII		
ar	St.	ate	31. Date filed (Month, Day, Year	05/E W/ 32.	Registra Signa	A	imac C	'	CINO	= -vcc	EVIC	, ,,,,,		
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				partment of Health and N	lental Hygiene	
		_		ertificate of Death	Reg. No.2 ()	12 27494
П	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month     Day	3. Time of Death
elec.	Medic		Theodore Alfred Christensen  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	August 08	Year 2012 9:08 P M
1	Examin	er	1705 Grays Road	Port Republic	4c. County	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign
	Director	, .	111-12-2177 1 M 2 □ F 94 Yrs		(Month, Day, Year) 01/10/1918	New York
	ind show at	or	Usual Residence of Decedent           10a. State         10b. County         10c, City, Town or	Location		10d. Inside City Limits
	Aaryla 8a-f s tified	rect	Maryland   Calvert   Port Re	public		1 ☐ Yes 2 🏋 No
	the la or 2 pe no	Ϊ́	10e. Street and Number	10f. Zip Code	10g. Citizen of	
	th with ms 23 must	Funeral Director	1705 Grays Road	20676		d States
	or iter	by Fu	11. Marital Status  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Never Married 2 □ Married	<ol><li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecify Yes or No- Rican, etc.) 14. Rac Blac	ce - A <b>me</b> rican Indian, ck, White, etc.
036	rs afte ral", ( Exan	ed b	3 🕱 Widowed 4 □ Divorced If Yes, Give Year or Dates. WWII	1 ☐ Yes 2 ☐ No Specify:	Specify	white
2-0	2 hou "natu edical	Completed		cedent's Usual Occupation ve kind of work done during most of worki	na 16b. Kind of B	usiness/Industry
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d 2	iled w I Hygi other	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surnam	
ylar	d be f Menta <b>arke</b> d atic ev	2	Alfred Christensen	Agnes	Boberg	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	3	19a. Informant's Name/Relationship (Type, Print)   19b. M.   Arleen Strider- daughter   259	ailing Address (Street and Number or Rura 5 Garrity Road St.	l Route Number, City or Town, S Leonard, MD 20	State_Zip Code) 685
Baltimore,	of He of He If item			rematory or other place)		- City or Town, State
ţi	t. Pag rtment rtant: njury c		4 Donation 5 Other (Specify) Holy Ro			y, New York
Bal	permi Depar Impor any ir		21. Signature of Puneyal Service Licensee	22. Name and Address of Facility Rau 4405 Broomes Is. Rd	sch Funeral Ho . Port Republi	me PA c MD 20676
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	· -		Approximate Interval Between
	Medical	p q	Immediate Cause (Final disease or condition resulting in death)	NAL FAILURE		Onset and Death
	Examiner		Due to (or as a consequence of):	2 ARDINGA	14/10/ 5/15	ST Y FARS
Lite.		iner	Sequential, list conditione, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):	C C SINVAGE	VLAID DISCOR	J. , C
	cuted ind transi	Examiner	Cause (Disease or injury that initiated events c.			
	cate be executed physician and s the burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):			
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89	eath certifica attending p	an/N	IF FEMALE: 23c. If yes, outcome of pregnancy   1	3 ☐ Ectopic pregnancy	23d. Da	te of delivery
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me		5 Other (specify)	Mc	onth Day Year
о <u>.</u>	requires that the der been signed by the s should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use conti	ribute to the cause of death?
ls,	puires i en sign	ed b	ATRIAL FIBRILLATION,	CONGESTIVE	1 🗆 Yes 2 🗔 🗤 0	3 ☐ Probably 4 ☐ Unknown
COL	aw rec as bee 2 sho	Completed	HEART FAILURE			Were autopsy findings available prior to completion of cause of
Ř	The law cate has I page 2 s	Con			performed?	death? 1 🗌 Yes 2 🗌 No
ita	Physician: The this certificate eral director, pag	Be o	25. Was case referred to medical examiner?  1  Yes 2  Hospital:   Inpution 2  FR (Quitos)	26. Place of Death (Check		
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ou	ath. r: Afte	icat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation injury	y work? M 1 ☐ Yes 2 ☐ No		
Division of Vital Records, P.O.	II or Attending P s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street and Number City or Town, State)	er or Rural Route Number,
٥	Hospital or 1 24 hours after Funeral Directory filled in t		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear	th occurred at the time, date and place, as	and due to the cause(s) and many	ner as stated
	To the Hosp within 24 hor To the Fune completely fi	Medical	(Check 2 Medical Examiner: On the basis of examination and/or involved only one) 3 Certifying Nurse Practitioner: To the best of my knowled	estigation, in my opinion, death occurred at	the time, date and place, and due	e to the cause(s) and manner stated.
	To the virthing of the complet		29b. Signature and title of certifier	29c. License number	29d. Date signed	d (Month, Day, Year)
			If Hezel my	026358	AUGU	151 7, 2012
Ri	9+1		30. Name and diddress of person who completed cause of death (Item 23a) (Type	Print) - POINTE 1.	-RENEDILL	15T9, 2012 1911-20678
,	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1/10/00	- DI RICK	111-000
E	Registra		AllG 10 2012 Denus	Barks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charles Frank Coyle, Jr. 2012 10:15 am Medical August Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 413-34-6409 **Director** 1**X** M 2 □ F 85 Feb. 11, 1927 Tennessee 28a-f show items 23a or 28a-f sho ler must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 3112 Gracefield Road, Apt. 323 20904 USA death v 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc Specify: White "natural", or þ 1 Never Married 2X Married ild be filed within 72 hours after i Mental Hygiene. 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Chemist Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be to Department of Health and Menta Important. If item 27 is marked any injury or other traumatic en Charles Frank Coyle, Sr. Edith Pauline Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Coyle/Son 2201 Dinwiddie Road, Virginia Beach, VA 23455 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 9, 1 Burial 2 CxCremation 3 Removal from State Aug. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2012 Alexandria, VA 21. Signature of Funeral Service Leense Francis J. Collins Funeral Home Inc. -500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dysphagia weeks Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Due to (or as a consequence on requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) Unknown a Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease, Atrial Fibrillation, 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of Diabetes Mellitus has autopsy performed? death? Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 🔀 No Other: ျ 1 Inpatient 2 FER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours at To the Funeral D completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

10

D57284

3110 Gracefield Road, Silver Spring ,MD 20904

Aug. 9, 2012

onan,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tuna

AUG 13 2012

Anna Korzan, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 August 9, Robert Eugene Crawford 4:30 PMM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northampton Manor Health Care Center Frederick Frederick 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 233-48-6855 Country) 1 PM 2 D F Director 82 June 11, 1930 West Virginia 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 424 Sherman Ave. 21701 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1 Q 5 ∩ \_ \_ . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: IT Yes, Give Year or Dates. 1950**-**195**4** Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Payroll Master 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie Virginia Bussard ဂ္ Vertis Luther Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)61 Wenner Drive, Brunswick, MD 21716 Ms. Michelle D. Crawford, PR injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of h Important: If ite any injury or ot 20c. Location - City or Town, State Resthaven Mem. Gardens Aug. 15, E Burial 2 ☐ Cremation 3 ☐ Removal from State 012 Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Basiord PA Funeral Home 106 Fast Church St., Frederick, M M01612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myo cand disease or condition mintes Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospital or Attending Physician: The law requires that the death of within 24 hours after death.

To the Leneral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for a in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 K Nursing Home 5 D Residence 6 D Other (Specify) မ 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 August 10, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zardi House Ave Frederick MD 21701 MO Jaces 801 Tou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

DHMH 17 Rev 06-2011

Division of Vital

 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $2012^{\text{Year}}$ August 4:30 P M Loraine Theresa Cole Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Hospita Ceci1 If Under 24 Hrs. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 X F 6/1<u>1/1930</u> Director 371-24-1913 82 MT Usual Residence of Decedent or 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? I Hygiene. other than "natural", or items 23a Funeral 249 Sycamore Road USA 21921 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black. White, etc. Yes 2 X No Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🕱 No 3 Divorced 4 Divorced Specify: Completed White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Mfg. - Chrysler Auto Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ဂ္ဂ Joseph Zaborski Mariam Zydleski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Cole - Husband 249 Sycamore Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 8/14/2012 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) aware Vet. Mem. Cemetery Bear, DE 22. Name and Address of Facility Signature of Funeral ervice R.T. Foard Funeral Home, PA 259 E. Main Street, Elkton, 23d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line.

Immediate Cause ( Approximate Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of executed and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed Yes 2 death? After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No after death Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number HD D0065733 08/09/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V-PULA RA 126 E. HIGH 31. Date filed (Month, Day, Registra s Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Elsie Dichtenberg Castleman 2012 August 11:00 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death Envoy of Denton Caroline Denton 8. Date of Birth (Month, Day, Year) Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) Days Hours Director 054-18-7989 1 □ M 2 🗓 F 89 Feb. 16 1923 New York Usual Residence of Decedent 28a-f show 10a. State be notified at 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Caroline Greensboro 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Examiner must 309 W. Sunset Ave. USA 21639 items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force þ Black, White, etc. "natural", or 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3X Widowed 4 □ Divorced Completed Year or Dates White Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4 or 5+) the 12 telephone operator New York Telephone Co Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Dichtenberg Rose Siegelwax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn Castleman/ daughter 309 W. Sunset Ave; Greensboro, Maryland : If item 2 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel 1 X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once. 4 Donation 5 Other (Specify) Aug 21 2012 Saddle Brook, New Jerse Riverside Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility PO Box 160; Greensboro, Fleegle and Helfenbein Funeral Home, PA; 21639 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) slio blastoma Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE asn 23b. Was decedent pregnant in the past 12 menths? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery in the past 12 month 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day Pregnant at time of death Month Year 9 Unknown Linknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Director: After this certificate has autopsy perform Yes 2 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation 1 Yes 2 No M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0023922 16/2013

DHMH 17 Rev 06-2011

State Registrar

1810

Rosa

Preston modiss

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3683

Registrar's Signature

Butus

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Linda Conti 1344 M Assunta AUAUST 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Memorial 101/601 HOSPITA aSTON Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Min. (Month, Day, Year) 143-42-1013 Director 1 □ M 2 🕅 F Yrs. 63 Aug. 15 1948 Pennsylvania ral", or items 23e or 28e-f sho Evaniner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 No Caroline Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14259 Benedictine Lane 21660 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. Completed by 1 X Never Married 2 Married Pege 1 and 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene. ent: if item 27 is merked other then "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates treumetic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) disabled n/a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Louis Conti, Sr. Marie Giannottasio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Conti/ brother 3516 Gunston RD; Alexandria, Virginia 22302 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) New St. Mary's Cem Aug 20 2012 Bellmawr, New Jersey 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD Fleegle and Helfenbein Funeral Home, PA; 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS DAYS Medical resulting in death) Examiner RESPIRATORY DISTRESS SYNDROME Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dust to (or as a nonsequence ory signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No erel Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Dipatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospitel or Attending 24 hours after death. 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WD Gramin 66441 D00 AUGUST 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2195 washington , Easton Ramesh 21601 31. Date filed (Month, Day, Year) 32. Registrar's aignature State

DHMH 17 Rev 06-2011

Registrar

AUG 1 7 2012

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0654 M Elizabeth Cassell Medical Marian 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Regional Medical umberlang Allegan 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Jun 15, 1928 Country Director 214-28-6259 1 □ M 2 □**X**F 84 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director Allegany Cumberland MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be Funeral 23a 21502 USA 10 Browning Street ed other than "natural", or items event, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) A & P Market Dept. Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grace I. Hardy Virgil E. Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Karen Shriver MD 21502 Cumberland 921 Lexington Avenue niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunset Memorial Park 8/22/2012 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service 22. Name and Address of Eacility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (o a consequence of) Examiner Sequentially list conditions, Examine Date follow cause. Enter Underlying Cause (Disease or injury that initiated events requires that the death certificate be executed -tran and resulting in death) Last Due to (or as a consequence burialphysician Physician/Medical P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
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3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) (Check To the I only one) 29b. Signature and title of c signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

**AUG 28** 

UAN

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)